LUCIA MAR UNIFIED SCHOOL DISTRICT ~ HUMAN RESOURCES
602-F Orchard Street, Arroyo Grande, CA 93420
(805)474-3000, ext. 1199 * Fax (805)473-4308

EMPLOYMENT PACKET FOR NEW SUBSTITUTE TEACHERS

Congratulations on your employment with the Lucia Mar Unified School District. We hope that your employment as a substitute teacher/student teacher will be a rewarding experience as a professional educator.

The following items below represent required forms to submit as well as informational items for your benefit. If you have any questions about the employment forms or future employment opportunities with Lucia Mar, please do not hesitate to contact me.

☐ **Fingerprinting for Employment** – *This is a priority on your checklist*. All new employees must have an employment background check in Human Resources. You cannot begin work as a substitute teacher until your clearance has been completed. Please schedule an appointment at luciamarschools.org/Employee/Volunteers & Fingerprinting.

☐ **Certificated Substitute Notifications** – Please review on the LMUSD Human Resources website (www.luciamarschools.org) the new Employee Notifications. Sign the Employee Acknowledgement form indicating that you have reviewed the acknowledgements. The **Oath** and **Computer Use Agreement** forms must be signed and returned to Human Resources.

☐ **Human Resources Data Sheet** – Please complete all sections of this form and return to Human Resources (2-sided).

☐ **Employee's Withholding Allowance Certificate (W-4)** – Please complete, sign and date this form and return to Human Resources.

☐ **Automatic Payroll Deposit Authorization Agreement** – Please attach a voided check to this form and return to Human Resources if you choose to have your payroll warrant automatically deposited.

☐ **STRS Permissive Election Form** – Complete this form by electing or declining membership into CalSTRS Retirement. Please note that CalSTRS has a mandatory enrollment once an employee has completed a set amount of work days in a school year. This information will be forwarded to our payroll office and the County Office of Education. If you are a current PERS member, please speak with our office.

☐ **Employment Eligibility Verification (Form I-9)** – Please complete **Section 1 only** of this form and return to Human Resources. You must have documents with you for us to verify. A current driver's license and Social Security card **or** Passport are the usual documents we verify. Please read Section 2 for a list of other documents (on the reverse side) which can be used, if necessary. This form and the accompanying documents **must be on file before your first day of work**.

☐ **Social Security Statement** – This is a statement regarding social security and retirement. Please read, sign and return.

☐ **Tuberculosis Clearance** – All persons initially employed by a school district must be tested to determine if he/she is free of active TB **not more than sixty (60) days prior to the date of being hired** *UNLESS* previously employed by another school district. Clearances must be renewed every four years. The initial clearance is at the employee's expense. Subsequent clearances are covered by the District.

☐ **Certificate of Medical Examination** – All persons initially employed by a school district must undergo a medical examination **not more than six (6) months prior to date of being hired** and have the form signed by a **licensed physician (MD or DO)**. This exam is at the employee's expense.

☐ **SIPE Training Modules** – Please complete all four (4) modules on the SIPE website before the first day of work. Completion of these modules is **mandatory**.

☐ **STRS Employment Data Questionnaire** – Please complete all questions. This information will be forwarded to our payroll office.

☐ **Substitute Teacher Information List** – This form is used to assign substitutes to jobs. Please fill out completely and return.

☐ **Instructional Calendar** – This is for your information only.

☐ **SubFinder Information** – Instructions and registration available on-line at www.luciamarschools.org.

☐ **Substitute Teacher Handbook** – For your information only. The Handbook can be accessed online @ www.luciamarschools.org.

☐ **Credentials** – Please submit a copy of your valid credential(s).

☐ **Affordable Care Act** – Health Insurance Marketplace Coverage Options and your Health Coverage. You can obtain coverage through the marketplace, www.healthcare.gov, Covered California, www.coveredca.com or contact Anthem directly at www.anthem.com for an individual plan. The intent of this notification is to provide general, not specific, information regarding the provisions of the Affordable Care Act (ACA). It should not be construed as, nor is it intended to provide, legal or financial advice.

☐ **Sexual Harassment Pamphlet-DFEH** – This is for your information only.

LUCIA MAR UNIFIED SCHOOL DISTRICT
HUMAN RESOURCES
602 ORCHARD ST.
ARROYO GRANDE, CA 93420
(805) 474-3000

SAN LUIS OBISPO COUNTY
SUBSTITUTE TEACHER APPLICATION

Date of Application _____

Social Security Number: _____

(In accordance with the Federal Privacy Act of 1974, disclosure of your social security number is voluntary. The social security number will be used for identification purposes to insure that proper records are maintained.)

I. PERSONAL DATA

Name: _____
Last First Middle

Present Address: _____

Telephone Numbers: (___) _____ (___) _____
Home Work

Former Name(s) Used: _____

Are you fluent in any language other than English? If so, please state language(s):_____

II. PREFERENCES

Grade Level/Specialty: Please check one or more categories:

[ ] Elementary School **[ ] Middle School*** **[ ] High School***

[ ] Community School (SLOCOE) **[ ] Preschool** **[ ] Special Education (SLOCOE)**

***Subject Matter: 1) _____ 2) _____ 3) _____**

III. EDUCATION AND PROFESSIONAL TRAINING

Name of University-City/State	Graduation Date	Degree	Major Subject(s)	Minor Subject(s)

Have you completed on or more of the Substitute Training Workshops at the San Luis Obispo County Office of Education?
YES _____ NO _____
(If yes please attach copy of certificate of completion)

ARE YOU RELATED TO ANY CURRENT LUCIA MAR EMPLOYEE? YES _____ NO _____
IF "YES", IN WHAT DEPARTMENT/SCHOOL DOES THIS PERSON WORK AND WHAT IS HIS/HER POSITION? _____
_____.

IV. CREDENTIAL INFORMATION

Before you can begin working, you must have (or at least have applied for) a valid California Teaching Credential which authorizes the service for which you are employed. Emergency 30 Day Substitute Permits are valid at the following districts:

Atascadero	San Luis Coastal (Secondary Schools Only)
Cayucos	San Luis Obispo County Office of Education
Lucia Mar	San Miguel
Paso Robles	Shandon
Pleasant Valley	Templeton

A. California Credentials you now hold (or have applied for):

Type	Authorization Subject	Expiration Date

If you have applied for a credential, but have not received it, you must show proof of application in order to receive a Temporary County Certificate which allows you to work while waiting to receive your credential.

B. Have you ever had any adverse action on your credential? **YES _____ NO _____**
(If yes, explain on a separate sheet of paper.)

C. Have you ever had any credential, application, permit, license or other document authorizing public school service or teaching suspended, revoked, voided, denied and/or otherwise rejected for cause in California or any other state?
YES _____ NO _____
(If yes, explain on a separate sheet of paper.)

D. Have you passed the CBEST? **YES _____ NO _____**

V. STUDENT TEACHING EXPERIENCE

	First Assignment	***Second Assignment***
Name and Location of School		
Name of District		
Grade Level and/or Subject		
Dates of Assignment		
Master Teacher's Name		

V. TEACHING EXPERIENCE

Dates of Employment: From: ____ To: ____ Full Time: ____ Part Time: ____ (if part-time, hours worked/week ____)

Type of Teaching Position: (Regular, Substitute, Temporary): _____

Name of District/Place of Employment: _____

Address of District/Place of Employment: _____

Name and Title of Supervisor: _____ *Phone Number:* _____

Grade Level and/or Subject Assignment: _____

Reason for Leaving: _____

Dates of Employment: From: ____ To: ____ Full Time: ____ Part Time: ____ (if part-time, hours worked/week ____)

Type of Teaching Position: (Regular, Substitute, Temporary): _____

Name of District/Place of Employment: _____

Address of District/Place of Employment: _____

Name and Title of Supervisor: _____ *Phone Number:* _____

Grade Level and/or Subject Assignment: _____

Reason for Leaving: _____

Dates of Employment: From: ____ To: ____ Full Time: ____ Part Time: ____ (if part-time, hours worked/week ____)

Type of Teaching Position: (Regular, Substitute, Temporary): _____

Name of District/Place of Employment: _____

Address of District/Place of Employment: _____

Name and Title of Supervisor: _____ *Phone Number:* _____

Grade Level and/or Subject Assignment: _____

Reason for Leaving: _____

VII. EXPERIENCE OTHER THAN TEACHING

Position	Employer	Location (City/State)	Dates of Employment

VIII. AFTER YOU ARE HIRED

The law requires written proof that you are entitled to work in the United States (i.e. Passport, Social Security Card, Birth Certificate, Driver's License, or other).

IX. PERSONAL DATA

A. Have you ever been discharged or requested to resign from a position? **YES _____ NO _____**
(If yes, explain on a separate sheet of paper.)

B. Have you ever been convicted of any felony or misdemeanor offense, including entering a plea of nolo contendere, in California or in any other state? **YES _____ NO _____**
If "Yes", please give the Section code of the offense and explain the circumstances _____
_____

Do you have a pending felony or misdemeanor case? **YES _____ NO _____**
(If yes, please attach a written statement explaining circumstances.)

(A conviction will not automatically bar you from consideration for employment. However, if you fail to disclose a conviction, that failure will disqualify you from the employment process. Education Code mandated under AB 1610 and AB 1612 prohibits hiring individuals convicted of narcotics, sex offenses or serious and violent crimes. Fingerprint criminal history clearance is required by law of all school employees prior to date of employment.)

X. REFERENCES: Please indicate references below & include those who have knowledge of your teaching experience, or any experience you have working with children.

Name	Position	District (or company and Address	Phone #

I hereby certify that the information contained in this application is true to the best of my knowledge and belief and acknowledge that any misrepresentation may result in an invalid application, denial of interview, loss of offer of employment and dismissal if employed. I release from all liability persons and organizations reporting information required by this application.

_____ _____
Date *Signature*

Note: If applying to multiple districts, you may duplicate this form before signing.
ORIGINAL SIGNATURE IS REQUIRED ON EACH APPLICATION

REQUIRED ATTACHMENTS: The following items must accompany each application in order to be considered for employment:

1. Copy of California Teaching Credential and/or Emergency 30 Day Substitute Permit (front and back).
2. Verification of TB Clearance.
3. College/University placement papers and/or three (3) current letters of reference.
4. Resume
5. Complete copies of transcripts (front and back).
6. California Basic Education Skills Test (CBEST) Verificatio

	Workers' Compensation: This is for your information.

7. n.

LUCIA MAR UNIFIED SCHOOL DISTRICT
Engage · Challenge · Inspire

Human Resources
602 Orchard Street, Arroyo Grande, CA 93420
(805) 474-3000 · Fax (805) 473-4308

Please complete this form and return to designated Human Resources Administrative Assistant or Human Resources Technician prior to beginning your employment.

Items for you to review have been placed on the Lucia Mar Unified School District (LMUSD) website www.luciamarschools.org within the Human Resources link. Please go to the website and review the documents listed below.

- BP 4020 Drug and Alcohol-Free Workplace
- BP & AR 4030 Nondiscrimination in Employment
- AR 4031 Complaints Concerning Discrimination in Employment
- BP & AR 4040 Employee Use of Technology
- E 4040 LMUSD Acceptable Use Policy and Computer Use Agreement
- AR 4212.3 Oath or Affirmation
- BP & AR 4219.11 Sexual Harassment
- BP & AR 4219.42 Exposure Control Plan for Bloodborne Pathogens and Hepatitis B vaccine declination (optional)
- BP & AR 5141.4 Child Abuse Prevention and Reporting
- BP & AR 4313.2 Promotion/Demotion/Reassignment *(Notice of release from position requiring an administrative or supervisory credential)*
- STRS Retirement/Benefits Information
- Family Medical Leave Act Handout
- Workers' Compensation Handout

Employee Acknowledgement:

The information listed above and on the LMUSD website outlines important information about the Lucia Mar Unified School District; I understand that I should consult the Human Resources department regarding any questions I may have. Since the information referred to on this page is subject to change, I acknowledge that revisions to the policies may occur. All such changes will be posted to the website and will be communicated to all employees.

I have reviewed all of the information listed above on _____ and understand that it is my responsibility to comply with the policies and any revisions made to them.

Printed Name: _____ Position/Title: _____

Signature: _____ Date: _____

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

I understand that as a public employee I am a disaster service worker pursuant to Government Code 3100 and 3102 and that I am required to take this oath before entering the duties of my employment. In the event of natural, manmade or war-caused emergencies which result in conditions or disaster or extreme peril to life, property and resources, I am subject to disaster services activities assigned to me by my supervisor.

_____
(Signature)

Certified by:

_____
(Person who administers the oath)

COMPUTER USE AGREEMENT – DISTRICT EMPLOYEE

I have read the District's Acceptable Use Policy and Computer Use Agreement and understand its provisions. I accept responsibility for the appropriate use of District computer resources. I understand that use of computer resources in violation of the Agreement may result in the revocation or restriction of user privileges and appropriate discipline. I agree to report any use which is in violation of the Agreement to the system administrator or appropriate employee supervisor.

_____
Employee [PRINT NAME]

_____
Signature

_____
Date

SIGN & DATE THE COMPUTER USE AGREEMENT (above)
RETURN THIS PAGE TO THE HUMAN RESOURCES DEPARTMENT

LUCIA MAR UNIFIED SCHOOL DISTRICT
HUMAN RESOURCES

EMPLOYEE DATA SHEET

NAME:	SSN:	DATE:

Residence Address: _____
Street City Zip

Mailing address, if different: _____

Phone Number _____ Birth Date: _____ Birthplace: _____

Marital Status: _____ Name of Spouse: _____ # of children & age_____

In case of emergency, contact (other than spouse):

_____
Name Phone Number Relationship

List any languages you speak other than English: _____

New federal requirements were established changing how race and ethnicity are collected for school district staff members. The following two part question follows this new guideline.

A. Are you Hispanic or Latino? (Select only one)
- ☐ No, not Hispanic or Latino
- ☐ Yes, Hispanic or Latino

The above part of the question is about ethnicity, not race. No matter what you selected above, please continue to answer the following by marking one of more boxes below:

B. What is your race? (Select one or more)

- ☐ American Indian or Alaska Native
- ☐ Asian Indian
- ☐ Black or African American
- ☐ Cambodian
- ☐ Chinese
- ☐ Filipino
- ☐ Guamanian
- ☐ Hawaiian
- ☐ Hmong
- ☐ Japanese
- ☐ Korean
- ☐ Laotian
- ☐ Other Asian
- ☐ Other Pacific Islander
- ☐ Samoan
- ☐ Tahitian
- ☐ Vietnamese
- ☐ White

Educational Preparation: If you have received any of the following degrees, please show from what institution, your major/minor. And the date received:

Associate's Degree: _____
Bachelor's Degree: _____
Master's Degree: _____
Doctorate: _____

OVER

The following information must be filed with the district prior to starting work:

DESIGNATION OF PERSON AUTHORIZED TO RECEIVE WARRANTS UPON DEATH OF EMPLOYEE:

DESIGNATION OF PERSON UNDER SECTION 53245, GOVERNMENT CODE, STATE OF CALIFORNIA:

I, _____, an employee of the Lucia Mar Unified School District, County of
(Employee name)

San Luis Obispo, do hereby appoint _____
(Name)

_____, _____ to
(Address **and** phone number) (Relationship)

Be the person entitled to receive all warrants and checks upon my death which would have been due and payable to me had I survived.

Date: _____ Signature: _____

Revised 07/09

San Luis Obispo County Office of Education
3350 Education Drive, San Luis Obispo, CA 93405

AUTOMATIC PAYROLL DEPOSIT AUTHORIZATION AGREEMENT

Employee:_____ Social Security Number:_____

District:___Lucia Mar USD_____ District Number:_____16_____

Select One: ☐ Checking Account ☐ Savings Account

I hereby authorize my employing district through San Luis Obispo County Office of Education and the financial institution shown on the check below, to deposit my net pay into my account. I shall hold harmless and indemnify the San Luis Obispo County Office of Education, herein after referred to as SLOCOE, and its officers and employees from any claim or demand of whatever nature, including those based upon negligence of SLOCOE, and its officers and employees brought by any person, including any banking institution against the SLOCOE in his/her capacity concerning the payroll warrant disposition provided by the SLOCOE.

I also agree to pay all fees incurred because of failure on my part to notify the San Luis Obispo County Office of Education of any changes in my account information that would result in a return of my deposit.

I understand it is my responsibility to ensure that my net check has been properly credited to my account before issuing checks against that account. If funds to which I am not entitled are deposited, I hereby authorize the San Luis Obispo County Office of Education either to direct the financial institution to return such funds or to request a "stop payment" of the automatic deposit and to issue a warrant for the correct amount. Electronic fund transfer takes effect on the next payroll following request after a successful prenote test has occurred through the banking system. This completed request is for the disposition of my pay warrant from the effective date specified until I have signed the cancellation section below.

_____ _____
Date Employee Signature

DEPOSITS TO CHECKING ACCOUNTS

ATTACH VOIDED PREPRINTED **CHECK** HERE
(Deposit slips are **NOT** acceptable.)

DEPOSITS TO SAVINGS ACCOUNTS

ATTACH VOIDED DEPOSIT SLIP HERE

Warning!

DO NOT COMPLETE THIS PORTION UNLESS YOU ARE *CANCELLING* YOUR DIRECT DEPOSIT!

Warning!

CANCELLATION

I hereby request that the San Luis Obispo County Office of Education discontinue direct deposits to the account number above, effective the next pay period after receipt of the request.

_____ _____
Date Employee Signature

Permissive Membership

ES 0350 (Rev. 6/11)

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

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

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

EMPLOYEE CERTIFICATION

NAME (LAST, FIRST, INITIAL)			CLIENT ID OR SOCIAL SECURITY NUMBER
MAILING ADDRESS			POSITION TITLE
CITY	STATE	ZIP CODE	HOME TELEPHONE ( )
E-MAIL ADDRESS			

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

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

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

SIGNATURE **DATE**

TO BE COMPLETED BY EMPLOYER

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

OFFICIAL'S SIGNATURE **TITLE**

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

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

ES0350

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 2005, the maximum monthly reduction in your Social Security benefit as a result of this provision is $313.50. 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** _____

LUCIA MAR UNIFIED SCHOOL DISTRICT
Human Resources Department

MEDICAL AND TUBERCULOSIS CLEARANCE FOR NEW CERTIFICATED EMPLOYEES

To ensure the attached forms are valid at the time of submission, do not proceed with these examinations until your employment has been officially approved.

Prior to official employment in any certificated position, you must provide, at your own expense, evidence of tuberculosis (TB) risk assessment and/or clearance and medical examinations. To avoid an unnecessary delay in our employment processing, your physician and you should read and follow all instructions below AND on the attached forms.

Tuberculosis Clearance for New Certificated Employees

All persons initially employed by a school district must be assessed and/or tested to determine if he/she is a risk for showing signs of TB and/or free of active TB **not more than sixty (60) days prior to the date of being hired.** The initial risk assessment must be completed according to the questionnaire provided by CDPH and CTCA. If a TB screening test must be completed because there are one or more risk factors associated to TB then an intradermal Mantoux tuberculin skin test (PPD) must be completed. A tine test is not acceptable. If the intradermal skin test is or has ever been positive (10mm or more), that test date must be indicated and chest x-ray results must be provided.

Certificate of Medical Examination

All persons initially employed by a school district must undergo a medical examination **not more than six (6) months prior to the date of being hired** and have the Certificate of Medical Examination Form signed by a **licensed physician (MD or DO).** Exams performed by Physician's Assistants and/or Nurse Practitioners must be countersigned by their supervising MD.

References: Ed Code 44839 & 49406, Administrative Regulations 4412.4(a)-(c), Title 5: 5504

LUCIA MAR UNIFIED SCHOOL DISTRICT
Human Resources Department

TUBERCULOSIS (TB) CLEARANCE FOR NEW CERTIFICATED EMPLOYEES

PLEASE NOTE: In accordance with California Education Code Section 49406, all persons initially employed by a school district must be examined to determine if he/she is free of active TB **not more than sixty (60) days prior to being hired.** The initial risk assessment must be completed according to the questionnaire provided by CDPH and CTCA. If a TB screening test must be completed because there are one or more risk factors associated to TB then an intradermal Mantoux tuberculin skin test (PPD) must be completed. A tine test is not acceptable.

The Genetic Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting, or requiring, genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic information," as defined by GINA, includes and individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Personal Information (Please Print)

_____ _____
Last Name First Name M.I. Social Security Number

_____ _____
Home Address City State Zip Birthday (mm/dd/yyyy)

_____
Phone Number Cell Number Email

Position: Early Education K-12 Adult Education
District Intern Substitute Other:_____

Risk Assessment Completed: _____
Mantoux Tuberculin Skin Test (5 TU PPD)
(If Skin Test Provided: Risk Factors)
Date Given: _____ ___

Date Read: _____

Result (mm induration): _____

_____
Signature of Practitioner Date

_____
Printed Name of Practitioner Date

_____
State License Number Degree

Chest X-ray (only if history of positive skin test)
Date (or estimated year) of positive skin test:_____

Date X-ray Taken: _____

Impression: _____

_____
Signature of Physician Date

_____
Printed Name of Physician Date

_____
State License Number Degree

Medical Facility's Contact Information

_____
Address City

_____
State Zip Phone Number

Candidate Must Submit Completed Form To: LMUSD Human Resources
602 Orchard Street
Arroyo Grande, CA 93420

LUCIA MAR UNIFIED SCHOOL DISTRICT
Human Resources Department

CERTIFICATE OF MEDICAL EXAMINATION

Personal Information (Please Print)

Last Name	First Name	M.I.	Social Security Number

Home Address	City	State	Zip	Birthday (mm/dd/yyyy)

Phone Number	Cell Number	Email

Position: Early Education / District Intern; K-12 / Substitute; Adult Education / Other:_____

The Genetic Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting, or requiring, genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic information," as defined by GINA, includes and individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

TO BE COMPLETED BY A LICENSED PHYSICIAN ONLY (M.D. OR D.O.)

On the basis of the patient's medical history and medical examination performed on him/her, I certify that this individual is free from any disabling disease unfitting him/her to instruct or associate with children. I hereby certify I am licensed to practice as a physician, and further certify the following:

1.	Is there evidence of disabling disease of the musculo-skeletal, cardio-vascular, nervous, gstro-intestinal, genitor-urinary, endocrine systems?	Yes	No
2.	Is there evidence of disabling disease affecting vision, hearing or speech?	Yes	No
3.	Is there evidence of disabling metabolic disease?	Yes	No
4.	Is there evidence of infectious disease in a communicable stage?	Yes	No
5.	Is there evidence of drug dependency including alcoholism?	Yes	No
6.	Is there evidence of any other disabling disease?	Yes	No

Details related to functions to be performed: _____

On the basis of my medical examination on (date) _____, the above named individual is free from disabling disease, except as noted above, which I believe unfits the individual to instruct, in the position for which application is being made, or to associate with children.

Printed Name of Physician	State License Number	Stamp/Phone Number

Signature of Physician	Today's Date	Date of Examination

TO BE COMPLETED BY THE CANDIDATE

I, _____, declare I have reviewed the above information and I attest to the accuracy of the information I provided to my medical practicioner as set forth herein above. I have reviewed all the questions and answers provided on this Certificate of Medical Examination and acknowledge they are truthful and do not contain any omissions.

Additionally, I understand, and I am fully aware (1) this examination must be conducted **not more than six (6) months prior to being hired,** (2) any incomplete and/or inaccurate information regarding my medical history may constitute grounds for the withdrawal and nullification of any offer of employment or separation from my current position if I'm found guilty of such violation.

Executed this _____ day of _____, 20_____, in _____, California, I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

_____
Signature

Candidate Must Submit Original To: LMUSD Human Resources
602-F Orchard Street
Arroyo Grande, CA 93420

Adult Tuberculosis (TB) Risk Assessment Questionnaire[1]

(To satisfy California Education Code Section 49406 and Health and Safety Code Sections 121525-121555)

To be administered by a licensed health care provider (physician, physician assistant, nurse practitioner, registered nurse)

Name: _____ Date of Risk Assessment: _____

Date of Birth: _____

History of positive TB test or TB disease Yes ☐ No ☐

If yes, a symptom review and chest x-ray (if none performed in previous 6 months) should be performed at initial hire.*
If no, continue with questions below.

If there is a "Yes" response to any of the questions 1-5 below, then a tuberculin skin test (TST) or Interferon Gamma Release Assay (IGRA) should be performed. A positive test should be followed by a chest x-ray, and if normal, treatment for TB infection considered.

Risk Factors	
1. One or more signs and symptoms of TB (prolonged cough, coughing up blood, fever, night sweats, weight loss, excessive fatigue) Note: A chest x-ray and/or sputum examination may be necessary to rule out infectious TB.[2]	Yes ☐ No ☐
2. Close contact with someone with infectious TB disease	Yes ☐ No ☐
3. Birth in high TB-prevalence country** (**Any country other than the United States, Canada, Australia, New Zealand, or a country in Western or Northern Europe.)	Yes ☐ No ☐
4. Travel to high TB-prevalence country** for more than 1 month (**Any country other than the United States, Canada, Australia, New Zealand, or a country in Western or Northern Europe.)	Yes ☐ No ☐
5. Current or former residence or work in a correctional facility, long-term care facility, hospital, or homeless shelter	Yes ☐ No ☐

**Once a person has a documented positive test for TB infection that has been followed by an x-ray that was deemed free of infectious TB, the TB risk assessment is no longer required.*

[1] Adapted from a form developed by Minnesota Department of Health TB Prevention and Control Program and Centers for Disease Control and Prevention.

[2] Centers for Disease Control and Prevention (CDC). *Latent Tuberculosis Infection: A Guide for Primary Health Care Providers*. 2013. (http://www.cdc.gov/tb/publications/LTBI/default.htm)

ADULT TUBERCULOSIS (TB) RISK ASSESSMENT QUESTIONNAIRE

(To satisfy California Education Code Section 49406 and Health and Safety Code Sections 121525-121555)

CERTIFICATE OF COMPLETION

To be signed by the licensed health care provider completing the risk assessment and/or examination

Name: _____ **Date:** _____

Date of Birth: _____

The above named patient has submitted to a tuberculosis risk assessment. The patient does not have risk factors, or if tuberculosis risk factors were identified, the patient has been examined and determined to be free of infectious tuberculosis.

_____

Health Care Provider Signature

_____

Please Print Health Care Provider Name **Title**

_____

Office Address: Street **City** **State** **Zip Code**

_____

Telephone **Fax**

LUCIA MAR UNIFIED SCHOOL DISTRICT
Human Resources Department

GUIDELINES FOR EXAMING PHYSICIAN

The statements below are provided as an aid in the medical examination of applicants for instructional and non-instructional certificated positions in the Lucia Mar Unified School District.

PRIMARY FUNCTIONS OF INSTRUCTIONAL PERSONNEL
Serves in a school or center as a classroom teacher or instructor of one or more subjects and/or grade levels; maintains proper control and a suitable learning environment; and performs other professional duties such as instructional planning, communicating and conferring with students and parents, and supervising the activities of students within and outside the classroom.

PRIMARY FUNCTIONS OF NON-INSTRUCTIONAL PERSONNEL
Serves in an office, school, or center to provide service in support of students and/or instructional personnel; performs the professional duties of administrative, technical or resource personnel such as a physician, nurse, psychologist, librarian, counselor, instructional specialist or manager.

Mental Health:

1. Free of disabling psychiatric disorders that will prevent successful performance of the core duties of the position.
2. Exhibits emotional stability and mental alertness sufficient to cope with a classroom of students.

General Physical Abilities:

1. Auditory acuity and oral facility sufficient to respond to questions and to impart information to students, staff, and parents.
2. Able to life and carry items weighing at least 20 pounds.
    a. If your patient is applying for a special education, nursing, or physical therapist position, this may require lifting or restraining disabled students ranging from 50 to 150 pounds, with or without help.
3. Stamina to sit, stand, and move about for long periods of time and climb stairs.
4. Visual acuity to read texts and other printed instructional materials.

Special Physical Abilities:

1. Teacher of physical education:
    a. Stamina to ensure physical activity such as calisthenics, running, and jumping for sustained periods of time.
    b. Body flexibility and coordination sufficient to bend, stretch, twist, or reach out in order to demonstrate various sports, dance, and other physical education activities.
2. Teacher of occupational/vocational/trades/crafts subjects:
    a. Manual dexterity to use hand tools and power equipment.
    b. Auditory acuity to hear conversations in a noisy room and to discriminate among environmental (non-speech sounds).

Updated: 12.12.2014

EMPLOYMENT DATA

1. School Year: _____ District of Employment: _____

2. Name: _____ SS# _____
(First) (Middle) (Last)

3. Date of Birth: _____ Spouse's Name: _____

4. Mailing Address: _____

5. Phone Number: _____ Date Employment Began: _____

6. Grade or Position: _____ Status: Full-Time _____ Part-Time _____
(If Part-Time, please enter % of Full-Time)

Substitute: _____

7. Have you taught outside of California? _____ Where? _____

8. Number of years teaching in California? _____ Last County? _____

THE FOLLOWING QUESTIONS WILL BE USED TO DETERMINE YOUR STATUS WITH THE STATE OF TEACHERS RETIREMENT SYSTEM. AN INCORRECT ANSWER CAN RESULT IN MANDATORY COLLECTION OF CONTRIBUTIONS DUE TO THE RETIREMENT SYSTEM.

			YES	NO
9.	a.	Do you CURRENTLY have funds on deposit with STRS? (Answer NO if you have recently received a refund of these monies.)	☐	☐
	b.	Are you RETIRED from STRS and receiving a monthly pension?	☐	☐
	c.	Do you CURRENTLY have funds on deposit with the Public Employees' Retirement System?	☐	☐
	d.	Are you CURRENTLY employed in any other school district? If YES, list the name of district or districts, full- or part-time, and certificated or non-certificated status.	☐	☐

CERTIFICATED	NON-CERTIFICATED	FULL-TIME	PART-TIME	DISTRICT

	e.	If you are not CURRENTLY a STRS member, would you like to elect membership and begin contributions? If YES, please request a "Permissive Election Form."	☐	☐

Federal Social Security Regulations (Section 11332) requires all employees who are not members of a retirement system to participate in Social Security and Medicare. You have the opportunity to ELECT into the State Teachers' Retirement System even though at this time you do not qualify for mandatory membership. This decision is IRREVOCABLE.

NOTE: Some districts are using Alternative Retirement Plans instead of Social Security.

10.		Have you filed your credential with the San Luis Obispo County Superintendent of Schools Office? (YOUR CREDENTIAL MUST BE FILED OR VERIFICATION OF APPLICATION AND A 30-DAY TEMPORARY PERMIT IS SIGNED AND FILED IN THE COUNTY SUPERINTENDENT OF SCHOOLS OFFICE BEFORE YOU MAY BEGIN TEACHING.)	☐	☐

Lucia Mar Unified School District

SUBSTITUTE TEACHER
Subject Information List 2014-2015

PLEASE CHECK ONE OR MORE:
_____ Substitute Teacher/Home Teacher
_____ Literacy Support Tutor/Class Size Reduction (MUST be fully Credentialed)

DATE: _____
NAME: _____
ADDRESS: _____
CITY: _____
ZIPCODE: _____
PHONE/CELL: _____
DAYS OF WEEK AVAILABLE: _____
GRADES WILL TEACH: _____
EMAIL: _____

SECONDARY SUBJECTS WILLING TO TEACH:

Agriculture	_____	**Math**	_____
Art	_____	**Music K-12**	_____
Business	_____	**P.E.**	_____
Computer Science	_____	**Photography**	_____
Culinary Arts	_____	**Reading**	_____
Drama	_____	**Science**	_____
Economics	_____	**Social Studies**	_____
English	_____	**Speech**	_____
Foreign Language	_____	**Other Subjects:**	
Health	_____	_____	_____
Home Ec.	_____	_____	_____
Industrial Tech.	_____	_____	_____

OTHER SUBJECTS WILLING TO TEACH:

Elementary P.E. _____
Special Education:
K-6 _____
7-8 _____
9-12 _____
Bilingual Classes _____

CREDENTIALS: **Subjects**
_____ Elementary _____
_____ Secondary _____
_____ 30 Day Substitute Permit _____
_____ Credential Expiration Date _____

Major/Minor: _____

Are you related to anyone at LMUSD? Name/Site: _____

What happens to my school district contribution if I purchase insurance through the Health Insurance Marketplace?

If you purchase a health plan through the Health Insurance 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 (if any) to employer offered coverage is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Health Insurance Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by Lucia Mar Unified School District, please check your summary plan description or contact:

Michelle Rogers, mrogers@lmusd.org Phone: (805) 474-3000 x1199

For more information about coverage offered through the Health Insurance Marketplace please visit: **www.healthcare.gov.** The Health Insurance Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Health Insurance Marketplace and its cost. You will also be able to obtain an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area. If you decide to complete an application for coverage in the Health Insurance Marketplace, you will be asked to provide certain information about the health coverage offered by Lucia Mar Unified School District. You can obtain this information by contacting the individual listed above.

LUCIA MAR UNIFIED SCHOOL DISTRICT
Instructional Calendar 2014-2015

Date	Event	Month	S	M	T	W	Th	F	S	Stu. days in month	Total stu. days
					1	2	3	H	X		
July 4	Independence Day	JULY	X	X	X	X	X	X	X		
			X	X	X	X	X	X	X		
			X	X	X	X	X	X	X		
			X	X	X	X	X				
								1	2		
			3	X	X	X	X	X	9		
Aug 20	First Day of School	AUGUST	10	11	12	13	14	15	16	8	8
			17	SD	WD	20	21	22	23		
			24	25	26	27	28	29	30		
			31								
				H	2	3	4	5	6		
Sept 1	Labor Day	SEPTEMBER	7	8	9	10	11	12	13		
			14	15	16	17	18	19	20	21	29
			21	22	23	24	25	26	27		
			28	29	30						
						1	2	3	4		
			5	6	7	8	9	10	11		
Oct 17	1st Quarter Ends (HS/MS) [47 days]	OCTOBER	12	13	14	15	16	17	18	23	52
			19	20	21	22	23	24	25		
			26	27	28	29	30	31			
Nov 7	1st Trimester Ends (ES) [57 days]								1		
Nov 10	Staff Development Day (no students)		2	3	4	5	6	7	8		
Nov 11	Veterans Day	NOVEMBER	9	SD	H	12	13	14	15	13	65
Nov 24-28	Thanksgiving Recess		16	17	18	19	20	21	22		
			23	24	25	26	H	H	29		
			30								
				1	2	3	4	5	6		
Dec 19	2nd Quarter Ends (HS/MS) [33 days]	DECEMBER	7	8	9	10	11	12	13		
			14	15	16	17	18	19	20	15	80
Dec 22-31	Winter Recess		21	22	23	H	H	26	27		
			28	29	30	31					
Jan 1-9	Winter Recess						H	2	3		
Jan 1	New Year's Day		4	5	6	7	8	9	10		
Jan 12	School Resumes	JANUARY	11	12	13	14	15	16	17	14	94
			18	H	20	21	22	23	24		
Jan 19	Martin Luther King, Jr. Day Observed		25	26	27	28	29	30	31		
			1	2	3	4	5	6	7		
Feb 13	Lincoln's Birthday Observed	FEBRUARY	8	9	10	11	12	H	14	18	112
			15	H	17	18	19	20	21		
Feb 16	Presidents' Day Observed		22	23	24	25	26	27	28		
March 6	Teacher Work Day		1	2	3	4	5	WD	7		
March 5	2nd Trimester Ends (ES) [59 days]		8	9	10	11	12	13	14		
March 5	3rd Quarter Ends (HS/MS) [36 days]	MARCH	15	16	17	18	19	20	21	21	133
			22	23	24	25	26	27	28		
			29	30	31						
April 5	Easter Day					1	2	3	4		
April 6-10	Spring Break		5	6	7	8	9	10	11		
		APRIL	12	13	14	15	16	17	18	17	150
April 17	STAR Testing Begins		19	20	21	22	23	24	25		
			26	27	28	29	30				
								1	2		
			3	4	5	6	7	8	9		
May 21	STAR Testing Ends	MAY	10	11	12	13	14	15	16	20	170
			17	18	19	20	21	22	23		
			24	H	26	27	28	29	30		
May 25	Memorial Day		31								
				1	2	3	4	5	6		
June 12	Last Day of School		7	8	9	10	11	MD	13		
June 12	3rd Trimester Ends (ES) [64 days]	JUNE	14	15	16	17	18	19	20	10	180
June 12	4th Quarter Ends (HS/MS) [64 days]		21	X	X	X	X	X	27		
			28	X	X	X	X	X	X		

KEY

	No Instruction (Recess, WD, SD, NS)	SD	Staff Development (no students)
H	Holiday Observed	WD	Teacher Work Day (no students)
	STAR Testing	MD	District Wide Minimum Day (for Students)
NS	Non-School Day (no students, no staff)		

Board Approved: 12/11/12

LUCIA MAR UNIFIED
SCHOOL DISTRICT

Human Resources
602 Orchard Street, Arroyo Grande, CA 93420
(805) 474-3000 • FAX (805) 473-4308

New Health Insurance Marketplace Coverage Options and Your Health Coverage

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 Lucia Mar Unified School District. Please note that this notice is informational only.

What is the Health Insurance Marketplace?

The Health Insurance 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 Health Insurance Marketplace begins in October 1, 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 does not meet certain standards**. The savings on your premium that you are eligible for depends on your household income.

Does Employment-Based Health Coverage Affect My 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 Health Insurance Marketplace and may wish to enroll in your employer's health plan, if you are eligible. (***Just because you received this notice does not mean you are eligible for the Lucia Mar Unified School District 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 your cost for self-only coverage under the Lucia Mar Unified School District health plan 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. 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 cost.

LUCIA MAR UNIFIED
SCHOOL DISTRICT

Human Resources
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(805) 474-3000 • FAX (805) 473-4308

Employee Frequently Asked Questions (FAQ's) on the Health Insurance Marketplace

Q: Why was the notice titled "New Health Insurance Marketplace Coverage Options and Your Health Coverage" sent to me?

A: As a part of the Affordable Care Act (ACA) that was passed in 2010, employers are required to provide this notice to all employees regardless of whether or not they are eligible to participate in Employment-Based Health Plans. This notice of the soon-to-launch Health Insurance Marketplace (also known as Exchanges) must be provided to all employees by October 1, 2013.

Q: Why is the Health Insurance Marketplace being established?

A: Under the ACA, beginning January 1, 2014 individuals will be required to have minimum essential health coverage, or else be subject to a penalty. This is referred to as the "individual mandate." The Health Insurance Marketplace is intended to help individuals meet the individual mandate requirement by providing another place to purchase coverage, and possibly qualify for federal assistance to do so. Information and details are available at www.healthcare.gov.

Q: Do I have to purchase health coverage through the Health Insurance Marketplace?

A: No. You may still obtain health coverage from other sources.

Q: What if I am covered under my employer's plan? Can I keep it?

A: Yes. Most Employment-Based Health Plans will qualify as the coverage required under the individual mandate requirements. You do not need to purchase coverage through the Health Insurance Marketplace in order to avoid the individual mandate penalty.

Q: Can I drop myself or my dependents from my Employment-Based Health Plan to purchase a plan through the Health Insurance Marketplace or outside of the Health Insurance Marketplace?

A: In some cases, yes, but in many cases, no. Employment-Based Health Plans have very specific rules around enrollment. In general, special enrollment and disenrollment are permitted during the year based on events such as marriage, divorce and the birth of a child. Generally, employees may not change unless the employee experiences a change in status allowed by the Employment-Based Health Plan. **SISC policy still requires full time employees to enroll & keep district health insurance; even if they would rather purchase coverage through the marketplace.**

Q: How do I know if I qualify for assistance to purchase my coverage through the Health Insurance Marketplace?

A: Individuals who are not offered qualifying healthcare coverage through their employer may be eligible for government subsidies to help pay for health insurance premiums for plans purchased in the Health Insurance Marketplaces. Subsidies are based on the household income level and how many dependents you have. If your employment-based health plan is considered affordable according to government definition and meets minimum value requirements, you won't be eligible for government subsidies on premiums in the Health Insurance Marketplace. This is true regardless of your household income and family size. As state Health Insurance Marketplaces sites are launched over the next months, you will be able to get details about a possible subsidy.

Q: I'm a 4 hour employee who declined district health benefits, can I get health insurance through the marketplace or elsewhere?

A: Yes, you have several options to obtain health coverage. You can obtain coverage through the marketplace, www.healthcare.gov, Covered California www.coveredca.com or contact Anthem directly at www.anthem.com for an individual plan.

The intent of this document is to provide general, not specific, information regarding the provisions of Affordable Care Act (ACA). It should not be construed as, nor is it intended to provide, legal or financial advice.

LUCIA MAR UNIFIED SCHOOL DISTRICT

2 TIER ANCHOR BRONZE PLAN BENEFIT SUMMARY

Introducing a new plan offering by SISC effective with the 2014-15 plan year in accordance with requirements of the Affordable Care Act.

Attention Lucia Mar Employees:

Part-time (less than 4 hours), Certificated & Classified Substitutes are eligible to sign up for the 2 Tier Anchor Bronze Plan. The full cost of the plan will be the employee's responsibility; no District contribution will be available for this group. Premiums will be paid 12 times per year and cannot be deducted from your payroll. See payment agreement for options provided for your convenience.

Features of the plan include:

- Medical and Prescription only with a $5,000 deductible. Plan coverage, once the deductible is met is 70% (you pay 30%). The Maximum Out-Of-Pocket (OOP) is $6,350 which may be comprised of a combination of the deductible, office co-pays and co-insurance payments. There is no option for dental, vision or life coverage through SISC if this plan is selected.
- Prescriptions are subject to the deductible, $5,000 before the designated prescription co-pays apply.
- This plan covers a single employee OR the employee + child(ren) ONLY - Spouses are NOT eligible on this plan.
- Premiums are on a two-tier structure of "single" (employee) or employee + child(ren).
- The plan year runs October 1 - September 30, but deductibles and OOP maximums reset on a *calendar-year* basis.
- Office visit co-pays are $60 for the first three visits (well visits do not count toward your (3) visits) After your 3rd visit you'll be subject to the deductible and co-insurance until the out-of-pocket maximum is met $6,350. This means the visit could cost substantially more depending on the services received. Once the OOP is met, the plan will pay at 100% for the remainder of the calendar year.
- Costco provides a $0 generic co-pay at their walk-in pharmacy (membership not required). The deductible

DID YOU KNOW??

Insurance industry standards (not the District, SISC, nor Anthem independently) require that:

* When one holds their own insurance plan as well as coverage under a spouse, the plan issued directly to them is **ALWAYS** that person's primary coverage; the spouse's coverage must be used as the secondary coverage. Use of a spouse's plan in lieu of your own to obtain a better, or more convenient, benefit is considered fraudulent and could be subject to audit by Anthem and/or the other provider resulting in back-charges due by you for any services incorrectly paid by the plan.
* When children are covered by both parents, the parent with the first birthday of the calendar year (not by age) is the primary coverage provider for the children; the other is the secondary coverage - you may not choose which order to apply the plans. Keep this in mind when selecting your plan to assure your children are covered most efficiently between the two plans. If the parent with the later birthday can provide better coverage for the children and you wish to make that their primary coverage, the first birthday parent must not cover them.

QUESTIONS OR CONCERNS? PLEASE CONTACT
MICHELLE ROGERS
805-474-3000 x1199 or mrogers@lmusd.org

2 TIER ANCHOR BRONZE PPO PLAN (70726B)

Offer for Part-time (4hrs or less), Substitutes & Coaches (receiving a stipend)

With the assistance of Self-Insured Schools of California (SISC), LMUSD is offering a plan in accordance with the Affordable Care Act effective 10/01/14. You are receiving this notice because our records indicate you fall within eligibility parameters. Enrollment in the plan is not required; however, in order to meet strict compliance requirements, you must return this form acknowledging receipt of the information providing the *opportunity* to enroll. If you wish to enroll, complete the online registration form or obtain enrollment paperwork from Human Resources if after 10/01.

ELIGIBILITY - All Certificated/Classified substitutes or coaches (receiving a stipend) or employees holding one or more positions totaling 3 hours per day, five days per week are eligible to opt-in to this plan. Those opting in may elect a coverage level of employee or employee + child(ren); **spouses, domestic partners and retirees may not be added.**

ENROLLMENT - Participation in the Bronze plan is voluntary. The plan year runs October 1 - September 30. Current staff and active subs eligible for the plan will be provided with a designated open enrollment period each year in which they may opt-in or out of the Bronze plan for the following plan year. If enrollment is elected, the employee must complete an enrollment form, provide required documentation (birth certificate) if enrolling dependent children, sign a payment agreement and remit the first premium payment due by the 20th of the month prior to the first coverage month. Those that choose to opt-out will be required to wait until the following year's open enrollment for the next opportunity to enroll. Newly-hired staff/subs falling within eligibility parameters of the plan will be provided the opportunity to enroll in time to begin coverage October 1st or the first day of the month following the date of hire (DOH) if hired mid-plan year, depending on DOH.

2 TIER ANCHOR BRONZE (70726B)

	Monthly Premium You Pay (10thly)
EMPLOYEE ONLY	**$454.00**
EMPLOYEE + CHILD	**$718.00**
EMPLOYEE + CHILDREN.	**$718.00**

70% ANTHEM BLUE CROSS PPO PLAN (GROUP #70308B)	
Medical **& Prescription** Deductible	$5,000 indiv / $10,000 fam
Calendar Year Out Of Pocket Max	$6,350 indiv / $12,700 fam
Office visit co-pay	$60/visit for first 3 visits, then subject to deductible and co-insurance
Prescriptions (generic / brand name)	$9 / $35 **AFTER** deductible is met

LUCIA MAR UNIFIED SCHOOL DISTRICT

Human Resources
602 Orchard Street, Arroyo Grande, CA 93420
(805) 474-3000 • FAX (805) 473-4308
Engage – Challenge- Inspire

Congratulations_____

Welcome to Lucia Mar Unified School District! We are excited to have you join our team. As an employee with Lucia Mar Unified School District effective _____ you are eligible to participate in our Health Benefits program. Please review the details and rates for the Anchor Bronze plan that were provided to you. You have 2 weeks from your date of hire to enroll for health benefits with the District. If no communication is received by _____ it will be understood that you are declining health insurance with Lucia Mar Unified School District. The next opportunity for you to enroll for health insurance would be during the next open enrollment period, plan year 10/1 – 9/30.

Please initial next to each item, indicating you understand your options.

_____ I acknowledge I have received an offer of health insurance for the Anchor Bronze Plan and was provided rates & a benefit summary to choose from.

_____ I acknowledge that I have received a copy of the Affordable Care Act notice with my offer of insurance.

_____ I understand if no communication is received by_____ then I am declining benefits with the District and my next opportunity to enroll would be during the next open enrollment period. 07/1-8/1 with a 10/01 effective date.

_____ Payments are made to LMUSD and are due on the 25th of the month. If no payment is received then your insurance will be dropped, effective the end of the month. Acceptable forms of payment are cash, cashier's check or money order. (5 day grace period granted)

_____ I acknowledge these items have been explained to me and that it is my responsibility to communicate my intentions to Lucia Mar Unified School District.

_____ I understand that in order to enroll I must contact Michelle Rogers at 805-474-3000 x1199 or mrogers@lmusd.org

****Disclosure: If you are a substitute or coach and work less than an average of 30 hours a week your insurance will be terminated the 1st of the month following the month less than 30 hours were worked. Any insurance payments owed to the District as a result of terminating your health benefits will be due within 10 business days from the date of the notice sent to you. The next opportunity to re-enroll will be during open enrollment.**

_____ _____ _____
Print Name Signature Date

_____ _____
Human Resources Representative Date

MANDATORY

SIPE Online Training Modules Certifications

All employees are **REQUIRED** to complete four (4) training modules on the SIPE website.

Website Instructions:

Go to: getsafetytrained.com

Click on "GetSafetyTrained.com" located within the gray box 
Under *User Sign In*, click on *Are You a New User*?
Under *New User Registration*, select "L" and choose *Lucia Mar Unified School District*

Complete all the requested information. Click on "View All Courses"

Complete all four modules:

- ☞ **Bloodborne Pathogens (under General Employee Safety)**
- ☞ **Staff & Student Relationships (under Property, Liability & Student Safety)**
- ☞ **Child Abuse Reporting (under Employment Practices & Workers' Compensation)**
- ☞ **Sexual Harassment (under Employment Practices & Workers' Compensation)**

Please plan to spend approximately 30+ minutes on each training session.
After you review each session, you may take the exam. Once you get 100% on the exam, a Certificate will show on the screen.

Print the certificates and submit to Human Resources.

MANDATORY

The definition of sexual harassment includes many forms of offensive behavior.

Department of Fair Employment and Housing

such as a lead, supervisor, manager or agent;

- the employer had no knowledge of the harassment;
- there was a program to prevent harassment; and
- once aware of any harassment, the employer took immediate and appropriate corrective action to stop the harassment.

Filing a Complaint

Employees or job applicants who believe that they have been sexually harassed may file a complaint of discrimination with DFEH within **one year** of the harassment.

DFEH serves as a neutral fact-finder and attempts to help the parties voluntarily resolve disputes. If DFEH finds sufficient evidence to establish that discrimination occurred and settlement efforts fail, the Department may file a formal accusation. The accusation will lead to either a public hearing before the Fair Employment and Housing Commission or a lawsuit filed by DFEH on behalf of the complaining party.

If the Commission finds that discrimination has occurred, it can order remedies including:

- Fines or damages for emotional distress from each employer or person found to have violated the law
- Hiring or reinstatement
- Back pay or promotion
- Changes in the policies or practices of the involved employer

Employees can also pursue the matter through a private lawsuit in civil court after a complaint has been filed with DFEH and a Right-to-Sue Notice has been issued.

For more information, see publication DFEH-159 "Guide for Complainants and Respondents."

For more information, contact DFEH toll free at
(800) 884-1684
Sacramento area & out-of-state at **(916) 478-7200**
TTY number at **(800) 700-2320**
or visit our Web site at ***www.dfeh.ca.gov***

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State of California
Department of Fair Employment & Housing

DFEH-185 (11/07)

Sexual Harassment

The Facts About Sexual Harassment

The *Fair Employment and Housing Act* (FEHA) defines sexual harassment as harassment based on sex or of a sexual nature; gender harassment; and harassment based on pregnancy, childbirth, or related medical conditions. The definition of sexual harassment includes many forms of offensive behavior, including harassment of a person of the same gender as the harasser. The following is a partial list of types of sexual harassment:

- Unwanted sexual advances
- Offering employment benefits in exchange for sexual favors
- Actual or threatened retaliation
- Leering; making sexual gestures; or displaying sexually suggestive objects, pictures, cartoons, or posters
- Making or using derogatory comments, epithets, slurs, or jokes
- Sexual comments including graphic comments about an individual's body; sexually degrading words used to describe an individual; or suggestive or obscene letters, notes, or invitations
- Physical touching or assault, as well as impeding or blocking movements



The mission of the Department of Fair Employment and Housing is to protect the people of California from unlawful discrimination in employment, housing and public accommodations, and from the perpetration of acts of hate violence.

Employers' Obligations

All employers must take the following actions against harassment:

- Take all reasonable steps to prevent discrimination and harassment from occurring. If harassment does occur, take effective action to stop any further harassment and to correct any effects of the harassment.
- Develop and implement a sexual harassment prevention policy with a procedure for employees to make complaints and for the employer to investigate complaints. Policies should include provisions to:
- Fully inform the complainant of his/her rights and any obligations to secure those rights.
- Fully and effectively investigate. The investigation must be thorough, objective, and complete. Anyone with information regarding the matter should be interviewed. A determination must be made and the results communicated to the complainant, to the alleged harasser and, as appropriate, to all others directly concerned.
- Take prompt and effective corrective action if the harassment allegations are proven. The employer must take appropriate action to stop the harassment and ensure it will not continue. The employer must also communicate to the complainant that action has been taken to stop the harassment from recurring. Finally, appropriate steps must be taken to remedy the complainant's damages, if any.
- Post the Department of Fair Employment and Housing (DFEH) employment poster (DFEH - 162) in the workplace (available through the DFEH publications line [916] 478-7201 or Web site).
- Distribute an information sheet on sexual harassment to all employees. An employer may either distribute this pamphlet (DFEH 185) or develop an equivalent document that meets the requirements of Government Code section 12950(b). This pamphlet may be duplicated in any quantity. **However, this pamphlet is not to be used in place of a sexual harassment prevention policy, which all employers are required to have.**
- All employees should be made aware of the seriousness of violations of the sexual harassment policy and must be cautioned against using peer pressure to discourage harassment victims from complaining.
- Employers who do business in California and employ 50 or more part-time or full-time employees *must* provide at least two hours of sexual harassment training every two years to each supervisory employee and to all new supervisory employees within six months of their assumption of a supervisory position.
- A program to eliminate sexual harassment from the workplace is not only required by law, but is the most practical way for an employer to avoid or limit liability if harassment should occur despite preventive efforts.

Employer Liability

All employers, regardless of the number of employees, are covered by the harassment section of the FEHA. Employers are generally liable for harassment by their supervisors or agents. Harassers, including both supervisory and non-supervisory personnel, may be held personally liable for harassing an employee or coworker or for aiding and abetting harassment.

Additionally, the law requires employers to take "all reasonable steps to prevent harassment from occurring." If an employer has failed to take such preventive measures, that employer can be held liable for the harassment. A victim may be entitled to damages, even though no employment opportunity has been denied and there is no actual loss of pay or benefits.

In addition, if an employer knows or should have known that a **non-employee** (e.g. client or customer) has sexually harassed an employee, applicant, or person providing services for the employer and fails to take immediate and appropriate corrective action, the employer may be held liable for the actions of the non-employee.

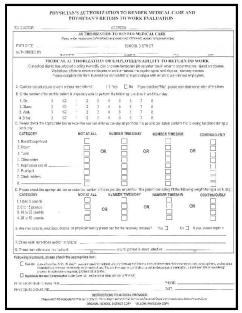
An employer might avoid liability if

- the harasser is not in a position of authority,

Reporting a Work Related Injury

During regular work hours an employee that is injured on the job after notifying their site secretary/supervisor, must then report to Human Resources when requesting medical treatment.

Worker's Compensation paper-work will be completed with Cyndie Clark, HR Technician.



At that time you will then be given the Physician's Authorization to Render Medical Care and Physician's Return to Work Evaluation and be directed to Med Plus for treatment.

YOU SHOULD NOT GO BACK TO WORK. You **MUST** report back to Cyndie Clark at Human Resources with this form completed by the physician at Med Plus. A determination will be made at that time regarding your work status.

<u>If you cannot return to work due to doctor's orders or district non-accommodation</u>:

Injured employees receive 60 days of Industrial Accident Leave and/or 60 days of Accommodation time. This time does not accumulate year to year. Once you have exhausted this time and all other leave balances available and you cannot work you will be placed on 5 month's differential pay. This is your pay minus the cost of a long term sub. If you do not have enough in your paycheck to cover your health premiums and regular payroll deductions you will be responsible for your insurance premiums. If you are still unable to return to work after exhausting all paid leave you will be given 5 months of differential pay and once that is exhausted you will then be placed on the 39 month re-employment list. ~Ed Code: 44977

<u>DOCTOR'S NOTES</u>

*Verification will need to be submitted to Human Resources for **all appointments** regarding a work related injury.

Verification will also need to be supplied for any **non-work related injuries where an employee is taken off work by their own personal physician.

***<u> Absences and verification of absences need to be forwarded to your Secretary as well as Human Resources Technician, Cyndie Clark</u>.

EMPLOYEE INCENTIVE PROGRAMS

50 Employees are randomly selected each month who complete and pass the monthly safety quiz provided by SIPE which is emailed to ALL staff.

http://www.wetip.com

WeTip is a 24-hour anonymous tip hotline for reporting information about a crime or threat. This service is available to all SLO County public school districts, Cuesta College, their students, parents, employees, and members of the community at no additional cost.

Lucia Mar Unified School District

602 Orchard St. Bldg -G
Arroyo Grande, CA 93420

Cyndie Clark, Human Resources Technician
Phone: 805-474-3000 ext. 1195
Fax: 805-473-4308
E-mail: cclark@lmusd.org

Lucia Mar Unified School District

California Worker's Compensation

Certificated Employees Injury Reporting Process and Return to Work Procedure

Cyndie Clark– Human Resources Technician
(805) 474-3000 ext. 1195

Employee Accident Report

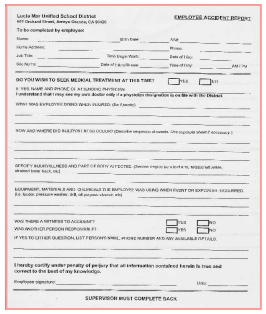
You injure yourself at work but you are not sure if this is a true injury or you decide maybe if I can sleep it off I will feel better the next morning.

What should you do?

ALWAYS fill out the Employee Accident Report. This is the first step in "getting" medical treatment should you decide that you will need treatment. The Employee Accident Report is notification to the district that you sustained a work related injury. **This should be done within 24 hours of the injury occurring** and should not be done after you have slept on it and decided the next morning you need treatment because you continue to experience pain or wake up with pain. Follow these important steps to ensure you have notified the district of your work injury:

1) Inform the site secretary or your supervisor of the injury, nature of the injury, and whether or not you need medical care.

2) Fill out the Employee Accident Report (give to the office secretary/ supervisor).



3) If you are requesting medical treatment contact Cyndie Clark immediately @ 474-3000 ext. 1192

I work before/after regular work hours and sometimes weekends what if I'm injured after hours?

If you are injured anytime outside of the regular 8 am to 5 pm work hours or when Human Resources is closed you should do the following: Contact your supervisor immediately. If your supervisor is not available leave a message on their work number. This is sufficient notification but REMEMBER an Accident Report will still need to be completed.

You may seek treatment at Med Plus for injuries from 8:00 am to 6 pm—Mon thru Fri. and Sat. 9 am to 3 pm.

If you need treatment after these hours go to the nearest hospital. If you go to the hospital you will need something in writing from the ER doctor stating any restrictions if you can return to work or if you cannot work at all.

On the following workday after the injury occurred or Monday whichever is closest, you will need to go to Human Resources and provide the documentation of your visit at Med Plus or the ER if you received treatment. Cyndie Clark (or designee) will review and you will begin filling out any required worker's compensation paperwork. A determination on whether you are able to return to work will be made at that time.

YOU MUST REPORT TO HUMAN RESOURCES **FIRST** BEFORE GOING TO WORK IN THE MORNING!
Human Resources is the only office that can provide you with clearance to return to work. If an accommodation is needed it will be discussed at that time.

Seek Treatment for Emergency type situations IMMEDIATELY. Call 911 or the Site Administrator for assistance.

STEPS TO REMEMBER IF I'M INJURED AT WORK

1. REPORT MY INJURY TO MY SUPERVISOR, SITE SECRETARY OR HUMAN RESOURCES.
2. COMPLETE EMPLOYEE ACCIDENT REPORT.
3. IF I WANT IMMEDIATE MEDICAL TREATMENT GO TO HUMAN RESOURCES AND SEE CYNDIE CLARK.
4. ONCE I'VE SPOKEN WITH CYNDIE CLARK AND COMPLETED THE NECESSARY WORKER'S COMP. PAPERWORK, I WILL THEN BE DIRECTED TO MED PLUS FOR TREATMENT WITH MY PHYSICIAN'S AUTHORIZATION TO RENDER MEDICAL TREATMENT AND RETURN TO WORK EVALUATION FORM.
5. AFTER MY APPT. I WILL RETURN TO HUMAN RESOURCES FOR WORK CLEARANCE AND TO SUBMIT MY PAPERWORK REGARDING MY DOCTOR'S VISIT.

If you find that a work injury in which you did not request medical treatment becomes worse, contact Cyndie Clark before seeking treatment.

If you seek treatment from your own personal physician prior to seeing Cyndie Clark:

1. You may be responsible for the costs associated with your visit since it will not be covered under worker's compensation OR:
2. You may receive a letter which may be placed in your personnel file regarding your failure to follow district procedures.

Work Accommodations

If the doctor states you can return to work with restrictions, it is the District's goal to return you to work as soon as possible. Please keep in mind this may not be in your usual and customary assignment and may involve you being placed on leave if an accommodation cannot be made.

Any changes to accommodations will be made by notification only through Cyndie Clark with a follow-up to your site Secretary.

FINGERPRINTING

$45.00

(For CA residents less than 1 year in state, add an additional $17.00)

*We accept checks or cash as payment.

All fingerprint services for volunteers/employees are

BY APPOINTMENT ONLY

To make an appointment go to:
luciamarschools.org/Employee/ Volunteers & Fingerprinting

Bring to Appointment:
A Valid Photo ID
(Driver's License or State ID, Military ID, Passport, etc.)

Location: Lucia Mar Unified School District
Human Resources
602-F Orchard Street, Arroyo Grande

Form W-4 (2015)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Personal Allowances Worksheet (Keep for your records.)

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

For accuracy, complete all worksheets that apply.

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

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

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

Employee's Withholding Allowance Certificate

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

OMB No. 1545-0074

2015

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

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

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

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

Deductions and Adjustments Worksheet

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

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

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

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

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

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

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

Table 1

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

Table 2

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

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

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

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

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

Instructions for Employment Eligibility Verification

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

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

Read all instructions carefully before completing this form.

Anti-Discrimination Notice. It is illegal to discriminate against any work-authorized individual in hiring, discharge, recruitment or referral for a fee, or in the employment eligibility verification (Form I-9 and E-Verify) process based on that individual's citizenship status, immigration status or national origin. Employers **CANNOT** specify which document(s) they will accept from an employee. The refusal to hire an individual because the documentation presented has a future expiration date may also constitute illegal discrimination. For more information, call the Office of Special Counsel for Immigration-Related Unfair Employment Practices (OSC) at 1-800-255-7688 (employees), 1-800-255-8155 (employers), or 1-800-237-2515 (TDD), or visit **www.justice.gov/crt/about/osc**.

What Is the Purpose of This Form?

Employers must complete Form I-9 to document verification of the identity and employment authorization of each new employee (both citizen and noncitizen) hired after November 6, 1986, to work in the United States. In the Commonwealth of the Northern Mariana Islands (CNMI), employers must complete Form I-9 to document verification of the identity and employment authorization of each new employee (both citizen and noncitizen) hired after November 27, 2011. Employers should have used Form I-9 CNMI between November 28, 2009 and November 27, 2011.

General Instructions

Employers are responsible for completing and retaining Form I-9. For the purpose of completing this form, the term "employer" means all employers, including those recruiters and referrers for a fee who are agricultural associations, agricultural employers, or farm labor contractors.

Form I-9 is made up of three sections. Employers may be fined if the form is not complete. Employers are responsible for retaining completed forms. Do not mail completed forms to U.S. Citizenship and Immigration Services (USCIS) or Immigration and Customs Enforcement (ICE).

Section 1. Employee Information and Attestation

Newly hired employees must complete and sign Section 1 of Form I-9 **no later than the first day of employment**. Section 1 should never be completed before the employee has accepted a job offer.

Provide the following information to complete Section 1:

Name: Provide your full legal last name, first name, and middle initial. Your last name is your family name or surname. If you have two last names or a hyphenated last name, include both names in the last name field. Your first name is your given name. Your middle initial is the first letter of your second given name, or the first letter of your middle name, if any.

Other names used: Provide all other names used, if any (including maiden name). If you have had no other legal names, write "N/A."

Address: Provide the address where you currently live, including Street Number and Name, Apartment Number (if applicable), City, State, and Zip Code. Do not provide a post office box address (P.O. Box). Only border commuters from Canada or Mexico may use an international address in this field.

Date of Birth: Provide your date of birth in the mm/dd/yyyy format. For example, January 23, 1950, should be written as 01/23/1950.

U.S. Social Security Number: Provide your 9-digit Social Security number. Providing your Social Security number is voluntary. However, if your employer participates in E-Verify, you must provide your Social Security number.

E-mail Address and Telephone Number (Optional): You may provide your e-mail address and telephone number. Department of Homeland Security (DHS) may contact you if DHS learns of a potential mismatch between the information provided and the information in DHS or Social Security Administration (SSA) records. You may write "N/A" if you choose not to provide this information.

All employees must attest in Section 1, under penalty of perjury, to their citizenship or immigration status by checking one of the following four boxes provided on the form:

1. **A citizen of the United States**
2. **A noncitizen national of the United States:** Noncitizen nationals of the United States are persons born in American Samoa, certain former citizens of the former Trust Territory of the Pacific Islands, and certain children of noncitizen nationals born abroad.
3. **A lawful permanent resident:** A lawful permanent resident is any person who is not a U.S. citizen and who resides in the United States under legally recognized and lawfully recorded permanent residence as an immigrant. The term "lawful permanent resident" includes conditional residents. If you check this box, write either your Alien Registration Number (A-Number) or USCIS Number in the field next to your selection. At this time, the USCIS Number is the same as the A-Number without the "A" prefix.
4. **An alien authorized to work:** If you are not a citizen or national of the United States or a lawful permanent resident, but are authorized to work in the United States, check this box.

   If you check this box:

   a. Record the date that your employment authorization expires, if any. Aliens whose employment authorization does not expire, such as refugees, asylees, and certain citizens of the Federated States of Micronesia, the Republic of the Marshall Islands, or Palau, may write "N/A" on this line.

   b. Next, enter your Alien Registration Number (A-Number)/USCIS Number. At this time, the USCIS Number is the same as your A-Number without the "A" prefix. If you have not received an A-Number/USCIS Number, record your Admission Number. You can find your Admission Number on Form I-94, "Arrival-Departure Record," or as directed by USCIS or U.S. Customs and Border Protection (CBP).

   (1) If you obtained your admission number from CBP in connection with your arrival in the United States, then also record information about the foreign passport you used to enter the United States (number and country of issuance).

   (2) If you obtained your admission number from USCIS *within the United States*, or you entered the United States without a foreign passport, you must write "N/A" in the Foreign Passport Number and Country of Issuance fields.

Sign your name in the "Signature of Employee" block and record the date you completed and signed Section 1. By signing and dating this form, you attest that the citizenship or immigration status you selected is correct and that you are aware that you may be imprisoned and/or fined for making false statements or using false documentation when completing this form. To fully complete this form, you must present to your employer documentation that establishes your identity and employment authorization. Choose which documents to present from the Lists of Acceptable Documents, found on the last page of this form. You must present this documentation no later than the third day after beginning employment, although you may present the required documentation before this date.

Preparer and/or Translator Certification

The Preparer and/or Translator Certification must be completed if the employee requires assistance to complete Section 1 (e.g., the employee needs the instructions or responses translated, someone other than the employee fills out the information blocks, or someone with disabilities needs additional assistance). The employee must still sign Section 1.

Minors and Certain Employees with Disabilities (Special Placement)

Parents or legal guardians assisting minors (individuals under 18) and certain employees with disabilities should review the guidelines in the *Handbook for Employers: Instructions for Completing Form I-9 (M-274)* on **www.uscis.gov/I-9Central** before completing Section 1. These individuals have special procedures for establishing identity if they cannot present an identity document for Form I-9. The special procedures include **(1)** the parent or legal guardian filling out Section 1 and writing "minor under age 18" or "special placement," whichever applies, in the employee signature block; and **(2)** the employer writing "minor under age 18" or "special placement" under List B in Section 2.

Section 2. Employer or Authorized Representative Review and Verification

Before completing Section 2, employers must ensure that Section 1 is completed properly and on time. Employers may not ask an individual to complete Section 1 before he or she has accepted a job offer.

Employers or their authorized representative must complete Section 2 by examining evidence of identity and employment authorization within 3 business days of the employee's first day of employment. For example, if an employee begins employment on Monday, the employer must complete Section 2 by Thursday of that week. However, if an employer hires an individual for less than 3 business days, Section 2 must be completed no later than the first day of employment. An employer may complete Form I-9 before the first day of employment if the employer has offered the individual a job and the individual has accepted.

Employers cannot specify which document(s) employees may present from the Lists of Acceptable Documents, found on the last page of Form I-9, to establish identity and employment authorization. Employees must present one selection from List A **OR** a combination of one selection from List B and one selection from List C. List A contains documents that show both identity and employment authorization. Some List A documents are combination documents. The employee must present combination documents together to be considered a List A document. For example, a foreign passport and a Form I-94 containing an endorsement of the alien's nonimmigrant status must be presented together to be considered a List A document. List B contains documents that show identity only, and List C contains documents that show employment authorization only. If an employee presents a List A document, he or she should **not** present a List B and List C document, and vice versa. If an employer participates in E-Verify, the List B document must include a photograph.

In the field below the Section 2 introduction, employers must enter the last name, first name and middle initial, if any, that the employee entered in Section 1. This will help to identify the pages of the form should they get separated.

Employers or their authorized representative must:

1. Physically examine each original document the employee presents to determine if it reasonably appears to be genuine and to relate to the person presenting it. The person who examines the documents must be the same person who signs Section 2. The examiner of the documents and the employee must both be physically present during the examination of the employee's documents.
2. Record the document title shown on the Lists of Acceptable Documents, issuing authority, document number and expiration date (if any) from the original document(s) the employee presents. You may write "N/A" in any unused fields.

   If the employee is a student or exchange visitor who presented a foreign passport with a Form I-94, the employer should also enter in Section 2:

   a. The student's Form I-20 or DS-2019 number (Student and Exchange Visitor Information System-SEVIS Number); **and** the program end date from Form I-20 or DS-2019.
3. Under Certification, enter the employee's first day of employment. Temporary staffing agencies may enter the first day the employee was placed in a job pool. Recruiters and recruiters for a fee do not enter the employee's first day of employment.
4. Provide the name and title of the person completing Section 2 in the Signature of Employer or Authorized Representative field.
5. Sign and date the attestation on the date Section 2 is completed.
6. Record the employer's business name and address.
7. Return the employee's documentation.

Employers may, but are not required to, photocopy the document(s) presented. If photocopies are made, they should be made for **ALL** new hires or reverifications. Photocopies must be retained and presented with Form I-9 in case of an inspection by DHS or other federal government agency. Employers must always complete Section 2 even if they photocopy an employee's document(s). Making photocopies of an employee's document(s) cannot take the place of completing Form I-9. Employers are still responsible for completing and retaining Form I-9.

Unexpired Documents

Generally, only unexpired, original documentation is acceptable. The only exception is that an employee may present a certified copy of a birth certificate. Additionally, in some instances, a document that appears to be expired may be acceptable if the expiration date shown on the face of the document has been extended, such as for individuals with temporary protected status. Refer to the *Handbook for Employers: Instructions for Completing Form I-9 (M-274)* or I-9 Central (www.uscis.gov/I-9Central) for examples.

Receipts

If an employee is unable to present a required document (or documents), the employee can present an acceptable receipt in lieu of a document from the Lists of Acceptable Documents on the last page of this form. Receipts showing that a person has applied for an initial grant of employment authorization, or for renewal of employment authorization, are not acceptable. Employers cannot accept receipts if employment will last less than 3 days. Receipts are acceptable when completing Form I-9 for a new hire or when reverification is required.

Employees must present receipts within 3 business days of their first day of employment, or in the case of reverification, by the date that reverification is required, and must present valid replacement documents within the time frames described below.

There are three types of acceptable receipts:

1. A receipt showing that the employee has applied to replace a document that was lost, stolen or damaged. The employee must present the actual document within 90 days from the date of hire.
2. The arrival portion of Form I-94/I-94A with a temporary I-551 stamp and a photograph of the individual. The employee must present the actual Permanent Resident Card (Form I-551) by the expiration date of the temporary I-551 stamp, or, if there is no expiration date, within 1 year from the date of issue.
3. The departure portion of Form I-94/I-94A with a refugee admission stamp. The employee must present an unexpired Employment Authorization Document (Form I-766) or a combination of a List B document and an unrestricted Social Security card within 90 days.

When the employee provides an acceptable receipt, the employer should:

1. Record the document title in Section 2 under the sections titled List A, List B, or List C, as applicable.
2. Write the word "receipt" and its document number in the "Document Number" field. Record the last day that the receipt is valid in the "Expiration Date" field.

By the end of the receipt validity period, the employer should:

1. Cross out the word "receipt" and any accompanying document number and expiration date.
2. Record the number and other required document information from the actual document presented.
3. Initial and date the change.

See the *Handbook for Employers: Instructions for Completing Form I-9 (M-274)* at **www.uscis.gov/I-9Central** for more information on receipts.

Section 3. Reverification and Rehires

Employers or their authorized representatives should complete Section 3 when reverifying that an employee is authorized to work. When rehiring an employee within 3 years of the date Form I-9 was originally completed, employers have the option to complete a new Form I-9 or complete Section 3. When completing Section 3 in either a reverification or rehire situation, if the employee's name has changed, record the name change in Block A.

For employees who provide an employment authorization expiration date in Section 1, employers must reverify employment authorization on or before the date provided.

Some employees may write "N/A" in the space provided for the expiration date in Section 1 if they are aliens whose employment authorization does not expire (e.g., asylees, refugees, certain citizens of the Federated States of Micronesia, the Republic of the Marshall Islands, or Palau). Reverification does not apply for such employees unless they chose to present evidence of employment authorization in Section 2 that contains an expiration date and requires reverification, such as Form I-766, Employment Authorization Document.

Reverification applies if evidence of employment authorization (List A or List C document) presented in Section 2 expires. However, employers should not reverify:

1. U.S. citizens and noncitizen nationals; or
2. Lawful permanent residents who presented a Permanent Resident Card (Form I-551) for Section 2.

Reverification does not apply to List B documents.

If both Section 1 and Section 2 indicate expiration dates triggering the reverification requirement, the employer should reverify by the earlier date.

For reverification, an employee must present unexpired documentation from either List A or List C showing he or she is still authorized to work. Employers CANNOT require the employee to present a particular document from List A or List C. The employee may choose which document to present.

To complete Section 3, employers should follow these instructions:

1. Complete Block A if an employee's name has changed at the time you complete Section 3.
2. Complete Block B with the date of rehire if you rehire an employee within 3 years of the date this form was originally completed, and the employee is still authorized to be employed on the same basis as previously indicated on this form. Also complete the "Signature of Employer or Authorized Representative" block.
3. Complete Block C if:
   a. The employment authorization or employment authorization document of a current employee is about to expire and requires reverification; or
   b. You rehire an employee within 3 years of the date this form was originally completed and his or her employment authorization or employment authorization document has expired. (Complete Block B for this employee as well.)

   To complete Block C:
   a. Examine either a List A or List C document the employee presents that shows that the employee is currently authorized to work in the United States; and
   b. Record the document title, document number, and expiration date (if any).
4. After completing block A, B or C, complete the "Signature of Employer or Authorized Representative" block, including the date.

   For reverification purposes, employers may either complete Section 3 of a new Form I-9 or Section 3 of the previously completed Form I-9. Any new pages of Form I-9 completed during reverification must be attached to the employee's original Form I-9. If you choose to complete Section 3 of a new Form I-9, you may attach just the page containing Section 3, with the employee's name entered at the top of the page, to the employee's original Form I-9. If there is a more current version of Form I-9 at the time of reverification, you must complete Section 3 of that version of the form.

What Is the Filing Fee?

There is no fee for completing Form I-9. This form is not filed with USCIS or any government agency. Form I-9 must be retained by the employer and made available for inspection by U.S. Government officials as specified in the **"USCIS Privacy Act Statement"** below.

USCIS Forms and Information

For more detailed information about completing Form I-9, employers and employees should refer to the *Handbook for Employers: Instructions for Completing Form I-9 (M-274)*.

You can also obtain information about Form I-9 from the USCIS Web site at www.uscis.gov/I-9Central, by e-mailing USCIS at **I-9Central@dhs.gov**, or by calling **1-888-464-4218**. For TDD (hearing impaired), call **1-877-875-6028**.

To obtain USCIS forms or the *Handbook for Employers*, you can download them from the USCIS Web site at www.uscis.gov/forms. You may order USCIS forms by calling our toll-free number at **1-800-870-3676**. You may also obtain forms and information by contacting the USCIS National Customer Service Center at **1-800-375-5283**. For TDD (hearing impaired), call **1-800-767-1833**.

Information about E-Verify, a free and voluntary program that allows participating employers to electronically verify the employment eligibility of their newly hired employees, can be obtained from the USCIS Web site at www.dhs.gov/E-Verify, by e-mailing USCIS at **E-Verify@dhs.gov** or by calling **1-888-464-4218**. For TDD (hearing impaired), call **1-877-875-6028.**

Employees with questions about Form I-9 and/or E-Verify can reach the USCIS employee hotline by calling **1-888-897-7781**. For TDD (hearing impaired), call **1-877-875-6028.**

Photocopying and Retaining Form I-9

A blank Form I-9 may be reproduced, provided all sides are copied. The instructions and Lists of Acceptable Documents must be available to all employees completing this form. Employers must retain each employee's completed Form I-9 for as long as the individual works for the employer. Employers are required to retain the pages of the form on which the employee and employer enter data. If copies of documentation presented by the employee are made, those copies must also be kept with the form. Once the individual's employment ends, the employer must retain this form for either 3 years after the date of hire or 1 year after the date employment ended, whichever is later.

Form I-9 may be signed and retained electronically, in compliance with Department of Homeland Security regulations at 8 CFR 274a.2.

USCIS Privacy Act Statement

AUTHORITIES: The authority for collecting this information is the Immigration Reform and Control Act of 1986, Public Law 99-603 (8 USC 1324a).

PURPOSE: This information is collected by employers to comply with the requirements of the Immigration Reform and Control Act of 1986. This law requires that employers verify the identity and employment authorization of individuals they hire for employment to preclude the unlawful hiring, or recruiting or referring for a fee, of aliens who are not authorized to work in the United States.

DISCLOSURE: Submission of the information required in this form is voluntary. However, failure of the employer to ensure proper completion of this form for each employee may result in the imposition of civil or criminal penalties. In addition, employing individuals knowing that they are unauthorized to work in the United States may subject the employer to civil and/or criminal penalties.

ROUTINE USES: This information will be used by employers as a record of their basis for determining eligibility of an employee to work in the United States. The employer will keep this form and make it available for inspection by authorized officials of the Department of Homeland Security, Department of Labor, and Office of Special Counsel for Immigration-Related Unfair Employment Practices.

Paperwork Reduction Act

An agency may not conduct or sponsor an information collection and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. The public reporting burden for this collection of information is estimated at 35 minutes per response, including the time for reviewing instructions and completing and retaining the form. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to: U.S. Citizenship and Immigration Services, Regulatory Coordination Division, Office of Policy and Strategy, 20 Massachusetts Avenue NW, Washington, DC 20529-2140; OMB No. 1615-0047. **Do not mail your completed Form I-9 to this address.**

Employment Eligibility Verification

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

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

►START HERE. Read instructions carefully before completing this form. The instructions must be available during completion of this form.
ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers **CANNOT** specify which document(s) they will accept from an employee. The refusal to hire an individual because the documentation presented has a future expiration date may also constitute illegal discrimination.

Section 1. Employee Information and Attestation *(Employees must complete and sign Section 1 of Form I-9 no later than the **first day of employment**, but not before accepting a job offer.)*

Last Name (*Family Name*)	First Name *(Given Name)*	Middle Initial	Other Names Used *(if any)*

Address (*Street Number and Name)*	Apt. Number	City or Town	State	Zip Code

Date of Birth *(mm/dd/yyyy)*	U.S. Social Security Number	E-mail Address	Telephone Number
	___-___-____		

I am aware that federal law provides for imprisonment and/or fines for false statements or use of false documents in connection with the completion of this form.

I attest, under penalty of perjury, that I am (check one of the following):

☐ A citizen of the United States

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

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

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

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

1. Alien Registration Number/USCIS Number: _____

OR

2. Form I-94 Admission Number: _____

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

Foreign Passport Number: _____

Country of Issuance: _____

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

3-D Barcode
Do Not Write in This Space

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

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

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

Signature of Preparer or Translator:			Date *(mm/dd/yyyy):*
Last Name *(Family Name)*	First Name *(Given Name)*		
Address *(Street Number and Name)*	City or Town	State	Zip Code

STOP ***Employer Completes Next Page*** STOP

Section 2. Employer or Authorized Representative Review and Verification

(Employers or their authorized representative must complete and sign Section 2 within 3 business days of the employee's first day of employment. You must physically examine one document from List A OR examine a combination of one document from List B and one document from List C as listed on the "Lists of Acceptable Documents" on the next page of this form. For each document you review, record the following information: document title, issuing authority, document number, and expiration date, if any.)

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

List A Identity and Employment Authorization	OR	List B Identity	AND	List C Employment Authorization
Document Title:		Document Title:		Document Title:
Issuing Authority:		Issuing Authority:		Issuing Authority:
Document Number:		Document Number:		Document Number:
Expiration Date *(if any)(mm/dd/yyyy)*:		Expiration Date *(if any)(mm/dd/yyyy)*:		Expiration Date *(if any)(mm/dd/yyyy)*:
Document Title:				
Issuing Authority:				
Document Number:				
Expiration Date *(if any)(mm/dd/yyyy)*:				
Document Title:				
Issuing Authority:				
Document Number:				
Expiration Date *(if any)(mm/dd/yyyy)*:				

3-D Barcode
Do Not Write in This Space

Certification

I attest, under penalty of perjury, that (1) I have examined the document(s) presented by the above-named employee, (2) the above-listed document(s) appear to be genuine and to relate to the employee named, and (3) to the best of my knowledge the employee is authorized to work in the United States.

The employee's first day of employment *(mm/dd/yyyy)*: _____ **(*See instructions for exemptions*.)**

Signature of Employer or Authorized Representative	Date *(mm/dd/yyyy)*	Title of Employer or Authorized Representative
Last Name *(Family Name)* First Name *(Given Name)*		Employer's Business or Organization Name
Employer's Business or Organization Address *(Street Number and Name)*	City or Town	State / Zip Code

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

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

C. If employee's previous grant of employment authorization has expired, provide the information for the document from List A or List C the employee presented that establishes current employment authorization in the space provided below.

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

I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented document(s), the document(s) I have examined appear to be genuine and to relate to the individual.

Signature of Employer or Authorized Representative:	Date *(mm/dd/yyyy):*	Print Name of Employer or Authorized Representative:

LISTS OF ACCEPTABLE DOCUMENTS
All documents must be UNEXPIRED

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

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

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

Refer to Section 2 of the instructions, titled "Employer or Authorized Representative Review and Verification," for more information about acceptable receipts.