

## **SUBSTITUTE TEACHER'S AIDE**

### CHECKLIST:

- \_\_\_ 1. **YELLOW CLASSIFIED APPLICATION**
- \_\_\_ 2. **ELECTRONIC LIVESCAN FINGERPRINT FORM**  
(See LiveScan Instructions- Applicant must have fingerprinting done for Napa County Office of Education)
- \_\_\_ 3. **A VALID T.B. TEST VERIFICATION** (must be within the last 4 years)
- \_\_\_ 4. **ORIGINAL SUPPORT DOCUMENTS FOR I-9 FORM**  
(to verify identity and employment eligibility – most commonly used are:  
a valid **Passport** or **Driver's License** AND a **Social Security Card**)
- \_\_\_ 5. **ALL DOCUMENTS IN THIS PACKET, COMPLETED**
  - Emergency Information
  - Oath of Office
  - Drug-Free Workplace policy
  - Child Abuse Reporting Requirements
  - Criminal Record Statement
  - Payroll Warrant Distribution form
  - Federal and State Tax Withholding forms
  - Employment Eligibility Verification (Form I-9)
  - Child Abuse Index Check form
- \_\_\_ 6. **WORKERS' COMP FORM** (Complete the attached form-only if you want your personal physician to treat you)

\*\*\* Please read and review the attached statement concerning your employment in a job that is not covered by Social Security and the APPLE program information.

**All forms must be signed by the applicant and dated.**

When you complete all items in this packet you will need to schedule a processing appointment, please contact:

Human Resources Department at  
(707) 253-6860

NAPA COUNTY OFFICE OF EDUCATION  
Barbara Nemko, Ph.D., Superintendent

2011

## ANNOUNCEMENT OF POSITION VACANCY



**POSITION**

**AVAILABLE:**

**Substitute Teacher's Aide**

Substitute aides may elect to work **on-call** in our child development centers; special education for infants, preschoolers, elementary, and/or secondary students; and/or in our juvenile/court/community school programs; and /or in the ROP programs. Applicants may elect to work in Napa, Yountville, St. Helena, and/or Calistoga.

**SALARY:**

\$11.18 per hour working on an **on-call as-needed basis**

**QUALIFICATIONS:**

Applicants must be eighteen years old, a high school graduate or the equivalent, be able to orally communicate with good articulation, speech, and language; read, understand, and follow written and verbal instructions; and provide instructional assistance under the direction of a teacher. In the children's centers, special education programs, and preschool centers some lifting, squatting, bending and toileting of children is required. Must be able to lift and assist the children. A Napa County Office of Education fingerprint clearance and a T.B. test are also required.

**APPLICATION  
PROCEDURE:**

Submit classified application, resume, three letters of reference and a narrative statement describing your qualifications for this position to the Human Resources Department located at 2121 Imola Avenue, Napa, CA 94559 or you may apply online at [www.edjoin.org](http://www.edjoin.org) or call (707) 265-2352.

**DEADLINE:**

Continuous filing

**NAPA COUNTY OFFICE OF EDUCATION**  
**2121 Imola Avenue**  
**Napa, CA 94559**  
**www.ncoe.k12.ca.us**

## **CLASSIFIED APPLICATION FOR EMPLOYMENT**

### Instructions and Information

- Please **complete all pages of the application fully and legibly** (type or print) **in ink**.
- Applications may be submitted in person, by e-mail (address listed above) or by mail. Applications and all required paperwork, stated in the job announcement, must be received by the deadline. *Postmarks are not acceptable.*
- Resume and supporting material may be attached; resume cannot be used to replace Employment History on application.
- Three letters of recommendation are required (none from relatives)
- A separate application packet must be submitted for each opening; photocopies may be submitted in place of an original application.
- Employment in public schools requires fingerprinting and hiring is regulated by Education Code Sections 44332.6, 44830.1, 44836, 45125, 45125.1, 44830.2, 45125.01, and 45125.2.
- A clear TB test is required upon employment.

### **EQUAL EMPLOYMENT OPPORTUNITY POLICY**

The Napa County Office of Education is an equal opportunity employer and is committed to an active nondiscrimination program. It is the stated policy of the Napa County Office of Education that all employees and applicants shall receive equal consideration and treatment. All recruitment, hiring, placements, transfers and promotions will be on the basis of qualifications of the individual for the positions being filled regardless of race, color, ethnic group identification, religion, ancestry, national origin, age (over 40 years), sex, marital status, sexual orientation, medical condition (cured or rehabilitated cancer as defined in Section 12926(f), Government Code 12990), or any mental or physical disability. All other personnel actions such as compensation, benefits, layoffs, return from layoffs, terminations, training, and social and recreational programs are also administered regardless of race, color, ethnic group identification, religion, ancestry, national origin, age (over 40 years), sex, marital status, sexual orientation, medical condition (cured or rehabilitated cancer as defined in Section 12926(f), Government Code 12990), or any mental or physical disability.

All decisions on employment and promotions must be made solely on the individual's qualifications and bona fide occupational qualifications for the job in question, and the feasibility of any necessary job accommodations.

# Napa County Office of Education

2121 Imola Avenue  
Napa, CA 94559  
[www.ncoe.k12.ca.us](http://www.ncoe.k12.ca.us)

For Office Use Only

Received \_\_\_\_\_  
Updated \_\_\_\_\_  
Interviewed \_\_\_\_\_  
DOJ \_\_\_\_\_  
ATI# \_\_\_\_\_  
SID# \_\_\_\_\_  
TB \_\_\_\_\_

## CLASSIFIED APPLICATION

POSITION DESIRED \_\_\_\_\_

Accounting/Payroll     Clerical     Custodial     Maintenance     Teacher's Aide

Status:     Full-time     Part time     Substitute     Temporary     On call/extra duty

## PERSONAL INFORMATION

First Name \_\_\_\_\_ Last Name \_\_\_\_\_ Middle Initial \_\_\_\_\_

Social Security Number \_\_\_\_\_ Drivers License No. \_\_\_\_\_

Mailing Address \_\_\_\_\_ Apt. # \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Fax \_\_\_\_\_ Email Address \_\_\_\_\_

California Public Employees' Retirement System (check current status)     Non-member

Current Member     Refunded Member - Date of Refund \_\_\_\_\_     Retired

Were you ever a member of STRS? (Calif. State Teachers' Retirement System)    \_\_\_yes    \_\_\_no

If yes, did you apply for a refund?    \_\_\_yes    \_\_\_no    Date of refund \_\_\_\_\_

**Clerical Applicants:** Check items for which you are trained or have experience:

Account Clerk \_\_\_\_\_ Clerk Typist \_\_\_\_\_ Receptionist \_\_\_\_\_ Secretary \_\_\_\_\_ Other \_\_\_\_\_

Typing Speed: \_\_\_\_\_ wpm    Do you have a current typing speed certificate?    \_\_\_yes    \_\_\_no

Please list the computer programs you have experience using: \_\_\_\_\_

**Teacher Aide Applicants:** Please indicate which area(s) you prefer to work

\_\_\_Preschool    \_\_\_Special Ed./Handicapped    \_\_\_Court/Comm. Schools    \_\_\_ROP

Do you have training in    CPR \_\_\_\_\_    First Aid \_\_\_\_\_    Other \_\_\_\_\_

List languages, other than English, that you are familiar with:

\_\_\_\_\_  Read     Speak     Write     Fluent     Some  
Sign Language \_\_\_\_\_  Fluent     Some

**Educational Record:**

Name of High School \_\_\_\_\_ City/State \_\_\_\_\_

Graduated  Highest grade completed \_\_\_\_\_ Passed GED

Name of College/School \_\_\_\_\_ City/State \_\_\_\_\_

Field of Study/Major \_\_\_\_\_

Units/Semester \_\_\_\_\_ Degree Awarded \_\_\_\_\_ Date \_\_\_\_\_

**EMPLOYMENT RECORD - Please list the most recent employer first**

1) Employer \_\_\_\_\_

Address \_\_\_\_\_ City/State \_\_\_\_\_

Duties \_\_\_\_\_

From \_\_\_\_\_ To \_\_\_\_\_ Hours/Week \_\_\_\_\_ Annual Salary \_\_\_\_\_

Name of Supervisor \_\_\_\_\_ Phone \_\_\_\_\_

Reason for leaving position \_\_\_\_\_

2) Employer \_\_\_\_\_

Address \_\_\_\_\_ City/State \_\_\_\_\_

Duties \_\_\_\_\_

From \_\_\_\_\_ To \_\_\_\_\_ Hours/Week \_\_\_\_\_ Annual Salary \_\_\_\_\_

Name of Supervisor \_\_\_\_\_ Phone \_\_\_\_\_

Reason for leaving position \_\_\_\_\_

3) Employer \_\_\_\_\_

Address \_\_\_\_\_ City/State \_\_\_\_\_

Duties \_\_\_\_\_

From \_\_\_\_\_ To \_\_\_\_\_ Hours/Week \_\_\_\_\_ Annual Salary \_\_\_\_\_

Name of Supervisor \_\_\_\_\_ Phone \_\_\_\_\_

Reason for leaving position \_\_\_\_\_

May we contact your previous employers? \_\_\_\_\_ yes \_\_\_\_\_ no

Are you currently or have you ever been employed by the Napa County Office of Education?

Yes  No  Dates of Employment/Positions held \_\_\_\_\_

### THREE PROFESSIONAL REFERENCES

- 1) Name \_\_\_\_\_  
Address \_\_\_\_\_ City/State \_\_\_\_\_  
Phone \_\_\_\_\_ Email \_\_\_\_\_  
Company/Title \_\_\_\_\_
- 2) Name \_\_\_\_\_  
Address \_\_\_\_\_ City/State \_\_\_\_\_  
Phone \_\_\_\_\_ Email \_\_\_\_\_  
Company/Title \_\_\_\_\_
- 3) Name \_\_\_\_\_  
Address \_\_\_\_\_ City/State \_\_\_\_\_  
Phone \_\_\_\_\_ Email \_\_\_\_\_  
Company/Title \_\_\_\_\_

### LEGAL INFORMATION

The following information is **REQUIRED** for your application to be considered. Your answers will not necessarily disqualify you from consideration, except for affirmative responses to certain enumerated sex and/or drug convictions and/or convictions for committing serious and/or violent felonies.

- 1) Can you, after employment, submit verification of your legal right to work in the U.S.? Yes  No
- 2) Do you have a valid driver's license? Yes  No   
State Issued in: \_\_\_\_\_ License No. \_\_\_\_\_ Expiration date: \_\_\_\_\_
- 3) Have you ever been convicted of a crime other than a minor traffic offense? Yes  No   
If yes, explain \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
- 4) Have you ever been dismissed or asked to resign from any position? Yes  No   
If yes, explain \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

- 5) My submission of this application authorizes the Napa County Office of Education to conduct a background investigation and authorizes release of information in connection with my application for employment. This investigation may include such information as criminal or civil convictions, driving records, previous employers and educational institutions, personal references, professional references, and other appropriate sources. I waive my right of access to any such information, and without limitation hereby release the Napa County Office of Education and reference source from any liability in connection to its release or use. This release includes the sources cited above and specific examples as follows: local law enforcement agencies, information from the Central Criminal Records Exchange or either data on all criminal convictions or certification that no date on criminal convictions are maintained, information from the California or other State Dept. of Social Services, Child Protective Services Unit & any locality to which they may refer for release of information to any findings of child abuse or neglect investigations involving me.

Furthermore, I certify that I have made true, correct and complete answers and statements on this application in the knowledge that they may be relied upon in considering my application, and I understand that any omission or falsely answered statement made by me on this application, or any supplement to it will be sufficient grounds for failure to employ or for my discharge should I become employed with Napa County Office of Education.

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

**Barbara Nemko, Ph.D., Superintendent**

NAPA COUNTY OFFICE



TO: All Employees  
FROM: Jill Cadloni, Human Resources Director  
DATE: July 14, 2010

We are now required to report our race/ethnicity data in a different manner. Thus, we need you to fill out the following information so that we can be in compliance with state and federal guidelines:

Please select one of the following:

Ethnicity:

- No, not Hispanic or Latino
- Yes, Hispanic or Latino
- Certify Non-Response

If you are not Hispanic or Latino please also select one of the following:

- American Indian/Alaskan
- Asian, Cambodian
- Asian, Chinese
- Asian, Hmong
- Asian, Indian
- Asian, Japanese
- Asian, Korean
- Asian, Laotian
- Asian, Other
- Asian, Vietnamese
- Black
- Certify Non-Response (Race)
- Filipino
- Other Non-White
- Pacific Islanders, Guamanian
- Pacific Islanders, Hawaiian
- Pacific Islanders, Other
- Pacific Islanders, Samoan
- Tahitian
- White

\_\_\_\_\_  
Print Your Name Here

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

*Distributed by*  
**NAPA COUNTY OFFICE OF EDUCATION**

**LIVE SCAN FINGERPRINTING PROCEDURE**

*PHOTO PRO • 1258 TRANCAS STREET •  
NAPA, CALIFORNIA  
(255-0772)*

**FOR EMPLOYMENT AS A SUBSTITUTE TEACHER AIDE,  
CERTIFICATED, OR CLASSIFIED EMPLOYEE**

1. Call Photo Pro at 255-0772 for an appointment. Live Scan is done Monday through Saturday during regular business hours.
2. Bring the following items:
  - a. A photo ID
  - b. \$15 made payable to Photo Pro  
Cash, personal check with ID, credit cards acceptable
  - c. The attached LiveScan form – **complete the personal information in Section 2**
3. Your fingerprints will be submitted electronically to the California Department of Justice. The Napa County Office of Education will receive your clearance information via email in approximately 3-7 days. You will receive a copy of the Request for LiveScan Service. Keep this copy for your records and as a receipt that you have completed this requirement. **DO NOT LOSE IT – IT CANNOT BE REPLACED.**

**8/4/09**

**REQUEST FOR LIVE SCAN SERVICE**  
*Applicant Submission for Public Schools or Joint Powers Agencies*

**ORI:** A0824  
Code assigned by DOJ

Type of Application: (check one)  Classified School Emp  Credentialed School Emp

**The following selections are for Public Schools only:**

License, Certification, Permit  Peace Officer  Law Enforcement Personnel  Volunteer

Job Title or Type of License, Certification or Permit: Classified Substitute Teacher's Aide

**Agency Address Set Contributing Agency:**

Napa County Office of Education  
Agency authorized to receive criminal history information  
2121 Imola Avenue  
Street No. Street or PO Box  
Napa, CA  
City State Zip Code

01879  
Mail Code (five-digit code assigned by DOJ)  
Jill Cadlioni  
Contact Name (Mandatory for all school submissions)  
(707) 253-6860  
Contact Telephone No.

Name of Applicant: \_\_\_\_\_  
(Please print) Last First MI

AKA's: \_\_\_\_\_  
Last First

CDL No. \_\_\_\_\_

DOB: \_\_\_\_\_ SEX:  Male  Female

Misc. No. BIL - 140441  
Agency Billing Number (if applicable)

HT: \_\_\_\_\_ WT: \_\_\_\_\_

Misc. No. \_\_\_\_\_

EYE Color: \_\_\_\_\_ HAIR Color: \_\_\_\_\_

Home Address: (Applies only if Youth Org/HRA or Public Utility submission)

POB: \_\_\_\_\_

\_\_\_\_\_  
Street or PO Box

SOC: \_\_\_\_\_

\_\_\_\_\_  
City, State and Zip Code

Your Number: \_\_\_\_\_  
OCA No. (Agency Identifying No.)

Level of Service  DOJ  FBI

If resubmission, list Original ATI No. \_\_\_\_\_

Live Scan Transaction Completed By: \_\_\_\_\_ Date \_\_\_\_\_  
Name of Operator

\_\_\_\_\_  
Transmitting Agency ATI No. Amount Collected/Billed

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Contact Telephone No.

**Name of Applicant:** \_\_\_\_\_  
(Please print) Last First MI

**AKA's:** \_\_\_\_\_  
Last First

**CDL No.** \_\_\_\_\_

**DOB:** \_\_\_\_\_ **SEX:**  Male  Female

**Misc. No.** BIL - 140441  
Agency Billing Number (if applicable)

**HT:** \_\_\_\_\_ **WT:** \_\_\_\_\_

**Misc. No.** \_\_\_\_\_

**EYE Color:** \_\_\_\_\_ **HAIR Color:** \_\_\_\_\_

**Home Address:** (Applies only if Youth Org/HRA or Public Utility submission)

**POB:** \_\_\_\_\_

\_\_\_\_\_  
Street or PO Box

**SOC:** \_\_\_\_\_

\_\_\_\_\_  
City, State and Zip Code

**Your Number:** \_\_\_\_\_  
OCA No. (Agency Identifying No.)

**Level of Service**  DOJ  FBI

If resubmission, list Original ATI No. \_\_\_\_\_

**Live Scan Transaction Completed By:** \_\_\_\_\_ **Date** \_\_\_\_\_  
Name of Operator

\_\_\_\_\_  
Transmitting Agency ATI No. Amount Collected/Billed

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(Please print) Last First MI

**AKA's:** \_\_\_\_\_  
Last First

**CDL No.** \_\_\_\_\_

**DOB:** \_\_\_\_\_ **SEX:**  Male  Female

**Misc. No.** BIL - 140441  
Agency Billing Number (if applicable)

**HT:** \_\_\_\_\_ **WT:** \_\_\_\_\_

**Misc. No.** \_\_\_\_\_

**EYE Color:** \_\_\_\_\_ **HAIR Color:** \_\_\_\_\_

**Home Address:** (Applies only if Youth Org/HRA or Public Utility submission)

**POB:** \_\_\_\_\_

\_\_\_\_\_  
Street or PO Box

**SOC:** \_\_\_\_\_

\_\_\_\_\_  
City, State and Zip Code

**Your Number:** \_\_\_\_\_  
OCA No. (Agency Identifying No.)

**Level of Service**  DOJ  FBI

If resubmission, list Original ATI No. \_\_\_\_\_

**Live Scan Transaction Completed By:** \_\_\_\_\_ **Date** \_\_\_\_\_  
Name of Operator

\_\_\_\_\_  
Transmitting Agency ATI No. Amount Collected/Billed

## T.B. Tests may be obtained by:

- Your private physician can do the skin test or a chest x-ray. This is at your own expense.
- **The Napa County Health Department #253-4270**  
2344 Old Sonoma Road, Napa

**Mondays:** T.B. tests are given by appointment only between the hours of 1:00 p.m. and 3:45 p.m. and will be read on the following Thursday between the same hours. You may pay the required payment of \$10.00 with cash or check. They do not make change.

**Tuesdays:** Drop-in appointments are between the hours of 1:00 p.m. and 3:45 p.m. and your T.B. test will be read on the following Thursday between the hours of 1:00 p.m. and 3:45 p.m.. You may pay the required payment of \$10.00 with cash or check. They do not make change.

Once you have your T.B. test done you will need to bring in the verification slip to the Human Resources Dept. so your file will be updated. The T.B. test is valid for four years. Thank you.

\* Some testing days may not be available during weeks that contain holidays.

**OFFICE OF THE SUPERINTENDENT  
NAPA COUNTY SCHOOLS  
Barbara Nemko**

**TO:** All Personnel

**RE:** Emergency Information

**FROM:** Jill Cadloni, Human Resources

We would like to have the following information for your personnel file in the event of an emergency:

Person to be notified \_\_\_\_\_

Relationship \_\_\_\_\_

Address \_\_\_\_\_

Telephone Number \_\_\_\_\_

Name of your Doctor \_\_\_\_\_

Address \_\_\_\_\_

Telephone Number \_\_\_\_\_

Signed \_\_\_\_\_

Date \_\_\_\_\_



# CHILD ABUSE INDEX CHECK FOR STATE LICENSED FACILITIES

DEPARTMENT OF SOCIAL SERVICES  
COMMUNITY CARE LICENSING  
CENTRALIZED FINGERPRINT UNIT  
744 P ST., MS 19-62  
SACRAMENTO, CA 95814

Complete **ALL** items checked (✓)

Include \$15.00 for each Child Abuse Index Check. (There is no exemption from this fee)  
Make check or money order payable to the Department of Justice.

**NOTE: APPLICANT/LICENSEE MUST SEND THIS FORM DIRECTLY TO DEPARTMENT OF JUSTICE, P.O. BOX 903417, SACRAMENTO, CA 94203-4170.**

*We are required by law to check the Child Abuse Index for all persons who apply for a license or seek employment in a child day care or residential facility caring for children. Persons required to submit a fingerprint card for a child care facility (day or residential) must also fill out this form. Please complete the information below. The Licensee is responsible for submitting fingerprint cards and this form to the Department of Justice along with appropriate fees.*

**TYPE OR PRINT INFORMATION**

✓ DATE SENT \_\_\_\_\_

NAME: LAST FIRST MIDDLE

DATE OF BIRTH — MO., DAY, YEAR SOCIAL SECURITY NUMBER

List all other names you have ever used:

MAIDEN NAME: NAME/AKA:

NAME/AKA: NAME/AKA:

CURRENT ADDRESS STREET CITY STATE ZIP CODE

MALE FEMALE FACILITY TELEPHONE NUMBER DRIVER'S LICENSE NUMBER

FACILITY NUMBER:

FACILITY NAME:

FACILITY ADDRESS: STREET CITY STATE ZIP CODE

✓ PERSONNEL TYPE OPTIONS

- A  FACILITY ADMINISTRATOR/DIRECTOR
- C  CORPORATION BOARD MEMBER
- E  EMPLOYEE
- F  CERTIFIED HOME (FFA)
- L  LICENSEE/APPLICANT
- N  NONCLIENT ADULT RESIDENT
- P  PARTNERSHIP MEMBER
- S  SPOUSE OF LICENSEE (Unless included as a licensee)
- U  UNKNOWN

FOR LICENSING OFFICE USE ONLY  
FOR FOLLOW-UP ONLY

Original Date Sent \_\_\_\_\_ Date Re-sent \_\_\_\_\_

**FOR DEPARTMENT OF JUSTICE USE ONLY**

- The result of a name search in the Child Abuse Index is as follows:
- The subject of the attached report **MAY** be the same as the subject of your inquiry.
  - No record on the above listed person.
  - Too many possible matches to identify. See attached listing.

**Signed Statement**  
**Child Abuse Reporting Requirements**

NOTE: PENAL CODE 11165, 11165.5 and 11166.5 REQUIRE THE FOLLOWING STATEMENT TO BE SIGNED BY EMPLOYEES INDICATING KNOWLEDGE OF THEIR OBLIGATION TO REPORT KNOWN OR SUSPECTED CASES OF CHILD ABUSE.

Section 11166 of the Penal Code requires any child care custodian, medical practitioner, nonmedical practitioner, or employee of a child protective agency who has knowledge of or observes a child in his or her professional capacity or within the scope of his or her employment whom he or she knows or reasonably suspects has been the victim of a child abuse to report the known or suspected instance of child abuse to a child protective agency immediately or as soon as practically possible by telephone and to prepare and send a written report thereof within 36 hours of receiving the information concerning the incident.

"Child care custodian" includes teachers, administrative officers, supervisors of child welfare and attendance, or certificated pupil personnel employees of any public or private school; administrators of a public or private day camp; licensees, administrators, employees of community care facilities or child day care facilities licensed to care for children; headstart teachers; licensing workers or licensing evaluators; public assistance workers; employees of a child care institution including, but not limited to, foster parents, group home personnel, and personnel of residential care facilities; social workers or probation officers; administrators or presenters of, or counselors in, a child abuse prevention program in any public or private school; and instructional aides, teacher aides, or teacher assistants employed by any public or private school and classified employees of any public school, who have been trained in the duties of child abuse reporting, if so warranted to the State Department of Education.

"Medical practitioner" includes physicians and surgeons, psychiatrists, psychologists, dentists, residents, interns, podiatrists, chiropractors, licensed nurses, dental hygienists, or any other person who is licensed under Division 2 (commencing with Section 500) of the Business and Professions Code or emergency medical technicians I or II, paramedics, or other persons certificated pursuant to Division 2.5 (commencing with Section 1797) of the Health and Safety Code, or psychological assistants registered pursuant to Section 2913 of the Business and Professions Code.

"Nonmedical practitioner" includes state or county public health employees who treat minors for venereal disease or any other condition; coroners; paramedics; marriage, family or child counselors; and religious practitioners who diagnose, examine, or treat children.

I have been informed of the above law and will comply with its provisions.

\_\_\_\_\_  
Employee's Name

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

\_\_\_\_\_  
Date

**DRUG AND ALCOHOL-FREE WORKPLACE**

The Governing Board believes that the maintenance of drug- and alcohol-free workplaces is essential to Napa County Office of Education operations and considers the Superintendent responsible for maintaining the Napa County Office of Education as a drug-free environment in accordance with the Drug-Free Workplace Act of 1988.

No employee shall unlawfully manufacture, distribute, dispense, possess, use or be under the influence of any alcoholic beverage, drug or controlled substance as defined in 21 USC 81 at any County Office workplace. These prohibitions apply before, during and after school hours.

*(cf. 4112.41/4212.41/4312.41 - Employee Drug Testing)*

*(cf. 4112.42/4212.42/4312.42 - Drug and Alcohol Testing for School Bus Drivers)*

The Superintendent or designee shall provide a drug and alcohol free workplace by:

1. Notifying employees that the unlawful manufacture, distribution, dispensation, possession or use of a controlled substance is prohibited in the workplace and specifying the actions that will be taken against employees for violation of such prohibition. (Government Code 8355; 41 USC 702)
2. Advising employees that the term "workplace" or "worksites" includes any place where County Office work is performed, any County Office-owned or County Office-approved vehicle used to transport students to and from County Office activities; any off-program sites when accommodating a County Office-sponsored or County Office-approved activity or function where students are under County Office jurisdiction; or during any period of time when an employee is supervising students on behalf of the County Office or otherwise engaged in County Office business.
3. Informing employees that:
  - a. The use of drugs or alcohol in the workplace not only may affect productivity and performance, but also may endanger the health, safety and welfare of the students, fellow employees, the public and the drug user.
  - b. It is the policy of the Napa County Office of Education to maintain a drug or alcohol free workplace.
  - c. Drug or alcohol counseling and rehabilitation programs are available (e.g. through employee health plans; employee assistance programs, etc.)
  - d. Use of drugs or alcohol in the workplace may result in criminal prosecution and/or disciplinary action in accordance with the Napa County Office of Education's collective bargaining agreements with its employees, policies, the California Education Code, and all other applicable state and federal laws and regulations.
4. Requiring that each employee receive a copy of a notice stating that as a condition of employment under any federal grant or contract, the employee shall:
  - a. Abide by the terms of the notice and the Napa County Office of Education's policy of maintaining a drug or alcohol free workplace.
  - b. Notify the employer of any criminal drug or alcohol statute conviction (including a plea of nolo contendere) for a violation occurring in the workplace no later than five days after such conviction:
5. Notifying the appropriate federal agency, within ten days after receiving notice under subparagraph (4) (b), from an employee or otherwise receiving actual notice of such conviction (41 USC 701)
6. Taking on of the following actions, within 30 days of receiving notice under subparagraph (4) (b), with respect to any employee who is so convicted:
  - a. Taking appropriate personnel action against such an employee, which may include termination; or
  - b. Requiring such employee to satisfactorily participate in a drug or alcohol abuse assistance or rehabilitation program approved for such purposes by a federal, state, or local health, law enforcement, or other appropriate agency.

*(cf. 4117.4 - Dismissal)*

*(cf. 4118 - Suspension/Disciplinary Action)*

*(cf. 4218 - Dismissal/Suspension/Disciplinary Action)*

7. Making a good-faith effort to continue maintaining a drug or alcohol free workplace through implementation of this policy.

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

*(cf. 4112 - Appointment and Conditions of Employment)*

*(cf. 4212 - Appointment and Conditions of Employment)*

**Drug and Alcohol-Free Workplace**

**SP4020(c)**

A classified employee may be reemployed after conviction of such an offense if the Board determines, from the evidence presented, that the person has been rehabilitated for at least five years. (Education Code 45123)

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

1. The dangers of drug and alcohol abuse in the workplace
2. The district policy of maintaining drug- and alcohol-free workplaces
3. Any available drug and alcohol counseling, rehabilitation, and employee assistance programs

*(cf. 4159/4259/4359 - Employee Assistance Programs)*

4. The penalties that may be imposed on employees for drug and alcohol abuse violations

Legal Reference:

EDUCATION CODE

- 44011 Controlled substance offense
- 44425 Conviction of controlled substance offenses as grounds for revocation of credential
- 44836 Employment of certificated persons convicted of controlled substance offenses
- 44940 Compulsory leave of absence for certificated persons
- 44940.5 Procedures when employees are placed on compulsory leave of absence
- 45123 Employment after conviction of controlled substance offense
- 45304 Compulsory leave of absence for classified persons

GOVERNMENT CODE

- 8350-8357 Drug-free workplace

UNITED STATES CODE, TITLE 20

- 7111-7117 Safe and Drug Free Schools and Communities Act

UNITED STATES CODE, TITLE 21

- 812 Schedule of controlled substances

CODE OF FEDERAL REGULATIONS, TITLE 21

- 1308.01-1308.49 Schedule of controlled substances

I have been informed of the above policy and will comply with its provisions.

\_\_\_\_\_  
Employee's Name

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

\_\_\_\_\_  
Date

## 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 the 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 the 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](http://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 \_\_\_\_\_

**CRIMINAL RECORD STATEMENT**

**INSTRUCTIONS:**

1. LICENSEE: See other side.
2. THE INDIVIDUAL COMPLETING THE STATEMENT: As a condition of your employment or presence in a community care facility, state law requires that you be fingerprinted and complete this affidavit.

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Have you ever been convicted of a crime?  
(Exclude any minor traffic violations for which the fine was  
\$50 or less)

YES

NO

If yes, attach a signed statement indicating the nature and  
circumstances of the crime(s).

I declare under penalty of perjury that I have read and understand the information contained in this  
affidavit and that my responses and accompanying attachments are true and correct.

---

Signature

County Where Signed

Date

**EMPLOYEE USE OF TECHNOLOGY**

**EMPLOYEE INTERNET USE AGREEMENT**

Employee's Name (Print)

---

The Napa County Office of Education ("County") offers access to the internet or intranet (collectively referred to as the "Net") under the following terms and conditions to the employee listed above ("Employee").

The Employee agrees that his/her use of the Napa County Office of Education's access to the internet shall be as follows:

1. **Educational Purposes.** I will restrict my use of the County's access to the internet and intranet ("Net access") only to educational purposes related to my assigned duties within the County and in ways which are reasonably related to the County's adopted curriculum and educational policies. I will not use the County's Net access for any illegal or immoral purpose. In this regard I will not use the County's Net access in any manner which would constitute computer hacking, violation of copyright laws, violation of trade secrets or licenses, invasion of another's privacy, gambling or use of bootleg software.
2. **Commercial Uses.** I will not use the County's Net access for private commercial purposes or for personal financial gain unless I have obtained permission to do so from the Deputy Superintendent of Business Services.
3. **Pornography and Hate Materials.** I will not use the County's Net access to access, send, or print material which is obscene, pornographic, or which dominant appeal is for sexual arousal. Nor will I use the County Net access to access, send, or print material which advocates hate or violence against others based on their race, national origin, gender, religion, age, disability, or sexual preference. Nor will I use the County's Net access to access, send, or print material which provide information which could be used in the production of destructive devices such as bombs, explosives, or fireworks.
4. **Other Prohibited Activities.** I shall also refrain from using abusive or profane language in either public or private messages sent on the County's Net access; from using the system to harass, insult, or attack others; from posting anonymous messages on the system; from using encryption software; from vandalizing the data of another user; from gaining unauthorized access to

resources or files; from identifying myself with another person's name or password or using an account or password of another user without proper authorization; from theft or vandalism of data, equipment, or intellectual property; from introducing a virus or otherwise improperly tampering with the system; from degrading or disrupting equipment or system performance; or from using County's Net access to invade the privacy of another.

- 5. Maintaining Records for Public Access:** I understand that "public records" includes any writing containing information relating to the conduct of the public's business prepared, owned, used, or retained by any state or local agency regardless of physical form or characteristics. "Writing" includes electronic mail. I further understand that public records are open to inspection at all times during the office hours of the County office and every person has a right to inspect any public record except as exempted by law. Should any person upon payment of fees covering direct costs of duplication, or a statutory fee if applicable, request any public record, an exact copy shall be provided promptly unless impracticable to do so.

Exemptions include:

- a. Preliminary drafts, notes or interagency or intra-agency memoranda that are not retained by the agency in the ordinary course of business provided that the public interest in withholding those records clearly outweigh the public interest in disclosure.
- b. Records pertaining to pending litigation until the claim has been finally adjudicated or otherwise settled.
- c. Personnel, medical or similar files, the disclosure of which would constitute an unwarranted invasion of personal privacy.
- d. Test questions, scoring keys, and other examination data used to administer a licensing examination, examination for employment or academic examination.
- e. The contents of real estate appraisals or engineering or feasibility estimates and evaluations made for or by the state or local agency relative to the acquisition of property, or to prospective public supply and construction contracts, until all of the property has been acquired or all of the contract agreement obtained.
- f. Library circulation records kept for the purpose of identifying the borrower or items.
- g. Records relating to student, attorney-client and personnel relating to privilege

- h. A document prepared by the County office that assesses its vulnerability to terrorist attack or other criminal acts intended to disrupt the public agency's operation.

It is not permissible to destroy public records.

Personal e-mails and "spam" do not constitute public records and may be deleted.

- 6. **Confidentiality and Public Record Statement:** I will include the following statement in my e-mail signature:

\*CONFIDENTIALITY NOTICE: This communication and any documents, files, or previous e-mail messages attached to it constitute an electronic communication within the scope of the Electronic Communications Privacy Act, 18 USCA 2510. This communication may contain non-public, confidential, or legally-privileged information intended for the sole use of the designated recipient/s. The unlawful interception, use, or disclosure of such information is strictly prohibited under USCA 2511 and any applicable laws.

Additionally, under the California Public Records Act most communications concerning business of a public agency are public records. This applies electronic communication such as "e-mail" sent by or received by a public employee acting in his/her official capacity.

- 7. **Supervision of Students.** I will provide reasonable supervision and instruction to students under my authority when they are using the County's Net access. In doing so I will reasonably attempt to see to it that students adhere to their responsibilities under the Student Net Use Agreement which each has signed.
- 8. **Limiting Students Who Use the Net.** I will allow only those students to use the County's Net access whom, along with their parent or guardian, have signed the Student Net Use Agreement.

---

Employee's Signature

---

Date

**Napa County Office of Education**  
**Barbara Nemko, Ph.D., Superintendent**

To All NCOE Employees:

California law requires Napa County Office of Education (NCOE) to notify its employees of certain rights and policies. This memo and the attached material are to inform you of relevant state laws, NCOE policies and rules, and the specific rights you have as an employee of NCOE.

**Uniform Complaint Procedure**

Napa County Office of Education has primary responsibility for insuring that it complies with state and federal laws and regulations that govern its employment practices. NCOE has a **Uniform Complaint Policy**, which is the procedure that is used for filing complaints alleging unlawful discrimination, sexual harassment, or failure to comply with the law in adult basic education, consolidation categorical aid programs, migrant education, vocational education, child care and development programs, child nutrition programs and special education programs. Attempts will be made to resolve issues at the local level.

The procedure requires timely filing, investigating, and resolving of all written complaints within a 60- day timeline, and includes an appeal process through the California Department of Education with a 60-day limit for resolution. Complainants should contact the Director of Human Resources for information regarding the uniform complaint procedure, at 253-6824, or the Administrator at the program site, or any NCOE administrator. The Uniform Complaint Procedure does not interfere with rights to all other civil procedures available to complainants, such as injunctions, restraining orders, private or public attorneys, public advocacy groups, mediation centers and civil courts. (CCR Title 5, Chapter 5.1, Subchapter 1, Articles 1-8)

**Discrimination**

The NCOE does not discriminate on the basis of race, color, ethnic group identification, religion, gender, marital status, sex, sexual orientation, parental status, age, disability, or status as a Vietnam-era veteran, in any of its employment practices as required by Title VI of the Civil Rights Act, Title IX of the Education Amendments, the Age Discrimination Act, Section 504 of the Rehabilitation Act, and the Vocational Educational Act. Unlawful discrimination also pertains to opposition to discriminatory practices, participation in any activity to enforce the UCP, affiliation with persons of color or ethnic group, or association with organizations promoting the interest of persons of color or ethnic group. All federal and state laws prohibiting discrimination and sexual harassment shall be enforced. The NCOE follows the guidelines established for affirmative action in order to assure that all personnel activities relevant to recruiting, hiring, and promoting employees guarantee equal opportunities.

**Sex Discrimination**

It is the policy of the NCOE to provide equal employment opportunities to individuals, regardless of their sex or sexual orientation. The NCOE also provides equal promotion opportunities to all employees regardless of sex or sexual orientation.

**Sexual Harassment**

Federal and state law and NCOE policy prohibit sexual harassment of any employee, student, staff or any other person at NCOE or any NCOE activity, educational programs, and employment practices. NCOE is committed to maintaining an environment that is free of harassment. Any employee who engages in, permits, or fails to report sexual harassment shall be subject to disciplinary action up to and including dismissal; with all federal and state laws enforced.

The NCOE prohibits retaliatory behavior against any complainant or any participant in the complaint process. Information related to a complaint of sexual harassment shall be confidential to the extent possible, and individuals involved in the investigation of such a complaint shall not discuss related information outside the investigation process.

**General Harassment**

The NCOE shall provide a work environment free from harassment. Unlawful harassment may take many forms, including: verbal conduct such as epithets, derogatory comments, slurs or unwanted sexual advances, invitations, or comments; visual conduct such as assault, blocking normal movement, or interference with work directed at you because of your sex or other protected basis; threats and demands to submit to sexual requests in order to keep your job or avoid some other loss, and offers of job benefits in return for sexual favors; retaliation for having reported the harassment. It is also the stated policy of NCOE to prevent and prohibit misconduct on the job, including sexual harassment or any type of employee harassment by co-workers, subordinate employees, or supervisors. Any employee found to have acted in violation of the foregoing policies shall be subject to the appropriate disciplinary action, including warnings, reprimand, suspension, and or discharge.

Please review this information regarding your specific rights as an employee of NCOE.

I have reviewed this information.

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

# NOTICE

## EMPLOYEE RIGHTS

### Instructions:

This form is intended to meet the requirements of Health and Safety Code Sections 1596.881 and 1596.882 which require that employees be informed of their rights, at the time of employment, to filing complaints against their employer for violating any licensing law or regulation. The child care facility licensee is required to give the employee this form, to have the employee complete and detach the bottom of the form, and to maintain the signed acknowledgement of receipt of the form in the employee's file.

No employer shall discharge, demote, suspend or threaten to discharge, demote or suspend, or in any manner discriminate against any employee for taking any of the following actions:

1. Making an oral or written complaint against the employer to the California Department of Social Services or other agency having statutory responsibility for enforcement of the law or to the employer or representative of the employer for the violation of any licensing law or other laws (including but not limited to laws relating to child abuse, staff-child ratios, etc.).
2. Instituting or causing to be instituted any proceeding against the employer regarding the violation of any licensing law or other laws.
3. Is, or will be, a witness or testifier in a proceeding regarding the violation of any licensing law or other law.
4. Refusing to perform work that is in violation of a licensing law or regulation after notifying the employer of the violation.

Pursuant to Health and Safety Code Section 1596.882, an employee alleging the violation by the employer of any action described above shall do the following:

1. Present the employer with a claim alleging violation of the employee's rights within 45 days after the discharge, demotion, suspension or threat thereof or for discriminating against the employee for taking such action.
2. File a claim with the Division of Labor Standards Enforcement no later than 90 days after the employer takes any of the above described actions against the employee.

Upon receipt of the employee's complaint, the Division of Labor Standards Enforcement shall do whatever investigation it deems appropriate to resolve the complaint. If it is determined that the employer has violated the employee's rights, the Division of Labor Standards Enforcement shall take action against the employer in any appropriate court. The court shall have jurisdiction of any action taken as well as to issue restraining orders and any other appropriate relief, including rehiring and reinstatements of the employee to his or her former position with backpay and benefits.

Within 30 days of receipt of a complaint from an employee as outlined above, the Division of Labor Standards Enforcement shall review the facts of the complaint and set either a hearing date or notify the employee and the employer of its decision. Where necessary, the Division of Labor Standards Enforcement shall begin the appropriate court action to enforce the decision.

Except for any grievance procedure or arbitration or hearing that is available to the employee pursuant to a collective bargaining agreement, Section 1596.882 is the exclusive means for presenting claims.

To file a claim with the Division of Labor Standards Enforcement, check the white pages of the local telephone directory under State Government Offices, California State of, Industrial relations Department, Labor Standards Enforcement-Working Conditions, for the local telephone number and address of the nearest office, or contact the headquarters office at P.O. Box 603, San Francisco, CA 94101, telephone (415) 703-4810.

(Detach Here)

(This form is to be retained in the employee's file)

### EMPLOYEE RIGHTS

This is to acknowledge that I \_\_\_\_\_ have received a copy of  
(PLEASE PRINT NAME OF EMPLOYEE)  
 "EMPLOYEE RIGHTS" from my employer \_\_\_\_\_, who is the  
(PLEASE PRINT NAME OF EMPLOYER)  
 licensee or authorized representative of \_\_\_\_\_  
(PLEASE PRINT NAME OF FACILITY)

\_\_\_\_\_  
(SIGNATURE OF EMPLOYEE)

\_\_\_\_\_  
(DATE)

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

**Form I-9, Employment Eligibility Verification**

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 documents have a future expiration date may also constitute illegal discrimination.

**Section 1. Employee Information and Verification** *(To be completed and signed by employee at the time employment begins.)*

Print Name: Last	First	Middle Initial	Maiden Name
Address <i>(Street Name and Number)</i>		Apt. #	Date of Birth <i>(month/day/year)</i>
City	State	Zip Code	Social Security #

**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 #) \_\_\_\_\_
- An alien authorized to work (Alien # or Admission #) \_\_\_\_\_ until (expiration date, if applicable - month/day/year)

Employee's Signature	Date <i>(month/day/year)</i>
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**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.*

Preparer's/Translator's Signature	Print Name
Address <i>(Street Name and Number, City, State, Zip Code)</i>	
Date <i>(month/day/year)</i>	

**Section 2. Employer Review and Verification** *(To be completed and signed by employer. Examine one document from List A OR examine one document from List B and one from List C, as listed on the reverse of this form, and record the title, number, and expiration date, if any, of the document(s).)*

List A	OR	List B	AND	List C
Document title: _____		_____		_____
Issuing authority: _____		_____		_____
Document #: _____		_____		_____
Expiration Date <i>(if any)</i> : _____		_____		_____
Document #: _____		_____		_____
Expiration Date <i>(if any)</i> : _____		_____		_____

**CERTIFICATION:** I attest, under penalty of perjury, that I have examined the document(s) presented by the above-named employee, that the above-listed document(s) appear to be genuine and to relate to the employee named, that the employee began employment on *(month/day/year)* \_\_\_\_\_ and that to the best of my knowledge the employee is authorized to work in the United States. (State employment agencies may omit the date the employee began employment.)

Signature of Employer or Authorized Representative	Print Name Jill G. Cadloni	Title Dir. of Human Resources
Business or Organization Name and Address <i>(Street Name and Number, City, State, Zip Code)</i> Napa County Office of Education, 2121 Imola Ave., Napa, CA 94559		Date <i>(month/day/year)</i>

**Section 3. Updating and Reverification** *(To be completed and signed by employer.)*

A. New Name <i>(if applicable)</i>	B. Date of Rehire <i>(month/day/year)</i> <i>(if applicable)</i>
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C. If employee's previous grant of work authorization has expired, provide the information below for the document that establishes current employment authorization.

Document Title: _____	Document #: _____	Expiration Date <i>(if any)</i> : _____
-----------------------	-------------------	---

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 <i>(month/day/year)</i>
--	------------------------------

## LISTS OF ACCEPTABLE DOCUMENTS

All documents must be unexpired

### LIST A

**Documents that Establish Both  
Identity and Employment  
Authorization**

### LIST B

**Documents that Establish  
Identity**

### LIST C

**Documents that Establish  
Employment Authorization**

OR

AND

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. Social Security Account Number card other than one that specifies on the face that the issuance of the card does not authorize employment in the United States
2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)		
3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa	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)
4. Employment Authorization Document that contains a photograph (Form I-766)	3. School ID card with a photograph	3. Certification of Report of Birth issued by the Department of State (Form DS-1350)
5. In the case of a nonimmigrant alien authorized to work for a specific employer incident to status, a foreign passport with Form I-94 or Form I-94A bearing the same name as the passport and containing an endorsement of the alien's nonimmigrant status, as long as the period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form	4. Voter's registration card	
	5. U.S. Military card or draft record	
	6. Military dependent's ID card	5. Native American tribal document
	7. U.S. Coast Guard Merchant Mariner Card	
	8. Native American tribal document	6. U.S. Citizen ID Card (Form I-197)
	9. Driver's license issued by a Canadian government authority	
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	<b>For persons under age 18 who are unable to present a document listed above:</b>	7. Identification Card for Use of Resident Citizen in the United States (Form I-179)
6. Passport from the Federated States of Micronesia (FSM) or the Republic of the Marshall Islands (RMI) with Form I-94 or Form I-94A indicating nonimmigrant admission under the Compact of Free Association Between the United States and the FSM or RMI	10. School record or report card	8. Employment authorization document issued by the Department of Homeland Security
	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)**

NAPA COUNTY SUPERINTENDENT OF SCHOOLS  
2121 Imola Avenue  
Napa, CA 94559-3610

AUTOMATIC PAYROLL DEPOSIT AUTHORIZATION

NAME: \_\_\_\_\_

SOCIAL SECURITY NUMBER: \_\_\_\_\_

Warrant Stub Distribution: Will Pick Up - \_\_\_\_\_

Please mail to - \_\_\_\_\_

\_\_\_\_\_  
*(This option is only available through 12/31/10)*

To sign up for automatic payroll deposit, please provide the following information. If you are having automatic deposit into your checking account please attach a blank voided check to this form. **If you are having automatic deposit into a savings account or an account with a CREDIT UNION, please have your Bank or CREDIT UNION furnish the following information:**

**Name of Institution:** \_\_\_\_\_

**Address of Institution:** \_\_\_\_\_

**Phone Number & Contact Person:** \_\_\_\_\_

**Transit ABA Number:** \_\_\_\_\_

**Sharedraft Account Number:** \_\_\_\_\_

**Savings Account Number:** \_\_\_\_\_

*I hereby authorize Napa County Office of Education to initiate deposits and/or corrections of my NET PAY to the financial institution indicated. The financial institution is authorized to credit and/or correct the amounts to my account. This authority is to remain in full force and effect until either I revoke it by giving ten days prior written notice to the employer designated above or upon termination of my employment with such employer.*

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date

# Form W-4 (2011)

**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 2011 expires February 16, 2012. 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 \$950 and includes more than \$300 of unearned income (for example, interest and dividends).

**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 may 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. 919, How Do I Adjust My Tax Withholding, 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. 919 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. 919 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. 919 to see how the amount you are having withheld compares to your projected total tax for 2011. See Pub. 919, especially if your earnings exceed \$130,000 (Single) or \$180,000 (Married).

## Personal Allowances Worksheet (Keep for your records.)

<b>A</b>	Enter "1" for <b>yourself</b> if no one else can claim you as a dependent . . . . .	<b>A</b>	
<b>B</b>	Enter "1" if: <ul style="list-style-type: none"> <li>• You are single and have only one job; or</li> <li>• You are married, have only one job, and your spouse does not work; or</li> <li>• Your wages from a second job or your spouse's wages (or the total of both) are \$1,500 or less.</li> </ul>	<b>B</b>	
<b>C</b>	Enter "1" for your <b>spouse</b> . 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.) . . . . .	<b>C</b>	
<b>D</b>	Enter number of <b>dependents</b> (other than your spouse or yourself) you will claim on your tax return . . . . .	<b>D</b>	
<b>E</b>	Enter "1" if you will file as <b>head of household</b> on your tax return (see conditions under <b>Head of household</b> above) . . . . .	<b>E</b>	
<b>F</b>	Enter "1" if you have at least \$1,900 of <b>child or dependent care expenses</b> for which you plan to claim a credit . . . . . ( <b>Note.</b> Do <b>not</b> include child support payments. See Pub. 503, Child and Dependent Care Expenses, for details.)	<b>F</b>	
<b>G</b>	<b>Child Tax Credit</b> (including additional child tax credit). See Pub. 972, Child Tax Credit, for more information. <ul style="list-style-type: none"> <li>• If your total income will be less than \$61,000 (\$90,000 if married), enter "2" for each eligible child; then less "1" if you have three or more eligible children.</li> <li>• If your total income will be between \$61,000 and \$84,000 (\$90,000 and \$119,000 if married), enter "1" for each eligible child plus "1" <b>additional</b> if you have six or more eligible children . . . . .</li> </ul>	<b>G</b>	
<b>H</b>	Add lines A through G and enter total here. ( <b>Note.</b> This may be different from the number of exemptions you claim on your tax return.) ▶ <b>H</b> For accuracy, <b>complete all worksheets that apply.</b> <ul style="list-style-type: none"> <li>• If you plan to <b>itemize or claim adjustments to income</b> and want to reduce your withholding, see the <b>Deductions and Adjustments Worksheet</b> on page 2.</li> <li>• If you have <b>more than one job or are married and you and your spouse both work</b> and the combined earnings from all jobs exceed \$40,000 (\$10,000 if married), see the <b>Two-Earners/Multiple Jobs Worksheet</b> on page 2 to avoid having too little tax withheld.</li> <li>• If <b>neither</b> of the above situations applies, <b>stop here</b> and enter the number from line H on line 5 of Form W-4 below.</li> </ul>		

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

<b>W-4</b> Form Department of the Treasury Internal Revenue Service	<b>Employee's Withholding Allowance Certificate</b> ▶ <b>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.</b>	OMB No. 1545-0074 <div style="font-size: 2em; font-weight: bold; text-align: center;">2011</div>
1 Type or print your first name and middle initial. Last name		2 Your social security number
Home address (number and street or rural route)		3 <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Married, but withhold at higher Single rate. <b>Note.</b> 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. <input type="checkbox"/>
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 2011, and I certify that I meet <b>both</b> of the following conditions for exemption. <ul style="list-style-type: none"> <li>• Last year I had a right to a refund of <b>all</b> federal income tax withheld because I had <b>no tax liability and</b></li> <li>• This year I expect a refund of <b>all</b> federal income tax withheld because I expect to have <b>no tax liability.</b></li> </ul> 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.		
<b>Employee's signature</b> (This form is not valid unless you sign it.) ▶		<b>Date</b> ▶
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.

<b>1</b>	Enter an estimate of your 2011 itemized deductions. These include qualifying home mortgage interest, charitable contributions, state and local taxes, medical expenses in excess of 7.5% of your income, and miscellaneous deductions . . . . .	<b>1</b>	\$ _____
<b>2</b>	Enter: $\left\{ \begin{array}{l} \$11,600 \text{ if married filing jointly or qualifying widow(er)} \\ \$8,500 \text{ if head of household} \\ \$5,800 \text{ if single or married filing separately} \end{array} \right\}$ . . . . .	<b>2</b>	\$ _____
<b>3</b>	<b>Subtract</b> line 2 from line 1. If zero or less, enter "-0-" . . . . .	<b>3</b>	\$ _____
<b>4</b>	Enter an estimate of your 2011 adjustments to income and any additional standard deduction (see Pub. 919)	<b>4</b>	\$ _____
<b>5</b>	<b>Add</b> lines 3 and 4 and enter the total. (Include any amount for credits from the <i>Converting Credits to Withholding Allowances for 2011 Form W-4 Worksheet</i> in Pub. 919.) . . . . .	<b>5</b>	\$ _____
<b>6</b>	Enter an estimate of your 2011 nonwage income (such as dividends or interest) . . . . .	<b>6</b>	\$ _____
<b>7</b>	<b>Subtract</b> line 6 from line 5. If zero or less, enter "-0-" . . . . .	<b>7</b>	\$ _____
<b>8</b>	<b>Divide</b> the amount on line 7 by \$3,700 and enter the result here. Drop any fraction . . . . .	<b>8</b>	_____
<b>9</b>	Enter the number from the <b>Personal Allowances Worksheet</b> , line H, page 1 . . . . .	<b>9</b>	_____
<b>10</b>	<b>Add</b> lines 8 and 9 and enter the total here. If you plan to use the <b>Two-Earners/Multiple Jobs Worksheet</b> , also enter this total on line 1 below. Otherwise, <b>stop here</b> and enter this total on Form W-4, line 5, page 1 . . . . .	<b>10</b>	_____

**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.

<b>1</b>	Enter the number from line H, page 1 (or from line 10 above if you used the <b>Deductions and Adjustments Worksheet</b> ) . . . . .	<b>1</b>	_____
<b>2</b>	Find the number in <b>Table 1</b> below that applies to the <b>LOWEST</b> paying job and enter it here. <b>However</b> , if you are married filing jointly and wages from the highest paying job are \$65,000 or less, do not enter more than "3" . . . . .	<b>2</b>	_____
<b>3</b>	If line 1 is <b>more than or equal to</b> 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. <b>Do not</b> use the rest of this worksheet . . . . .	<b>3</b>	_____

**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.

<b>4</b>	Enter the number from line 2 of this worksheet . . . . .	<b>4</b>	_____
<b>5</b>	Enter the number from line 1 of this worksheet . . . . .	<b>5</b>	_____
<b>6</b>	<b>Subtract</b> line 5 from line 4 . . . . .	<b>6</b>	_____
<b>7</b>	Find the amount in <b>Table 2</b> below that applies to the <b>HIGHEST</b> paying job and enter it here . . . . .	<b>7</b>	\$ _____
<b>8</b>	<b>Multiply</b> line 7 by line 6 and enter the result here. This is the additional annual withholding needed . . . . .	<b>8</b>	\$ _____
<b>9</b>	Divide line 8 by the number of pay periods remaining in 2011. For example, divide by 26 if you are paid every two weeks and you complete this form in December 2010. Enter the result here and on Form W-4, line 6, page 1. This is the additional amount to be withheld from each paycheck . . . . .	<b>9</b>	\$ _____

**Table 1**

**Table 2**

Married Filing Jointly		All Others		Married Filing Jointly		All Others	
If wages from <b>LOWEST</b> paying job are—	Enter on line 2 above	If wages from <b>LOWEST</b> paying job are—	Enter on line 2 above	If wages from <b>HIGHEST</b> paying job are—	Enter on line 7 above	If wages from <b>HIGHEST</b> paying job are—	Enter on line 7 above
\$0 - \$5,000 -	0	\$0 - \$8,000 -	0	\$0 - \$65,000	\$560	\$0 - \$35,000	\$560
5,001 - 12,000 -	1	8,001 - 15,000 -	1	65,001 - 125,000	930	35,001 - 90,000	930
12,001 - 22,000 -	2	15,001 - 25,000 -	2	125,001 - 185,000	1,040	90,001 - 165,000	1,040
22,001 - 25,000 -	3	25,001 - 30,000 -	3	185,001 - 335,000	1,220	165,001 - 370,000	1,220
25,001 - 30,000 -	4	30,001 - 40,000 -	4	335,001 and over	1,300	370,001 and over	1,300
30,001 - 40,000 -	5	40,001 - 50,000 -	5				
40,001 - 48,000 -	6	50,001 - 65,000 -	6				
48,001 - 55,000 -	7	65,001 - 80,000 -	7				
55,001 - 65,000 -	8	80,001 - 95,000 -	8				
65,001 - 72,000 -	9	95,001 - 120,000 -	9				
72,001 - 85,000 -	10	120,001 and over	10				
85,001 - 97,000 -	11						
97,001 - 110,000 -	12						
110,001 - 120,000 -	13						
120,001 - 135,000 -	14						
135,001 and over	15						

**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.



This form can be used to manually compute your withholding allowances, or you can electronically compute them at www.taxes.ca.gov/de4.xls (Microsoft Excel required).

EMPLOYEE'S WITHHOLDING ALLOWANCE CERTIFICATE

Form fields for Name, Social Security Number, Home Address, City, State, and ZIP Code, and Filing Status (SINGLE or MARRIED, MARRIED (one income), HEAD OF HOUSEHOLD).

Form fields for Number of allowances for Regular Withholding Allowances, Worksheet A; Total Number of Allowances (A + B) when using the California Withholding Schedules for 2011; Additional amount of State income tax to be withheld each pay period (if employer agrees), Worksheet C; and a certification statement with a check box.

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

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

Employer's Name and Address: NCOE, 2121 Imola Ave, Napa, CA 94559; California Employer Account Number.

----- cut here -----

Give the top portion of this page to your employer and keep the remainder for your records.

YOUR CALIFORNIA PERSONAL INCOME TAX MAY BE UNDERWITHHELD IF YOU DO NOT FILE THIS DE 4 FORM

IF YOU RELY ON THE FEDERAL FORM W-4 FOR YOUR CALIFORNIA WITHHOLDING ALLOWANCES, YOUR CALIFORNIA STATE PERSONAL INCOME TAX MAY BE UNDERWITHHELD AND YOU MAY OWE MONEY AT THE END OF THE YEAR.

PURPOSE: This certificate, DE 4, is for California personal income tax withholding purposes only. The DE 4 is used to compute the amount of taxes to be withheld from your wages, by your employer, to accurately reflect your state tax withholding obligation.

- You should complete this form if either: (1) You claim a different marital status, number of regular allowances, or different additional dollar amount to be withheld for California personal income tax withholding than you claim for federal income tax withholding or, (2) You claim additional allowances for estimated deductions.

THIS FORM WILL NOT CHANGE YOUR FEDERAL WITHHOLDING ALLOWANCES.

The federal Form W-4 is applicable for California withholding purposes if you wish to claim the same marital status, number of regular allowances, and/or the same additional dollar amount to be withheld for state and federal purposes. However, federal tax brackets and withholding methods do not reflect state personal income tax withholding tables. If you rely

on the number of withholding allowances you claim on your Form W-4 withholding allowance certificate for your state income tax withholding, you may be significantly underwithheld. This is particularly true if your household income is derived from more than one source.

CHECK YOUR WITHHOLDING: After your Form W-4 and/or DE 4 takes effect, compare the State income tax withheld with your estimated total annual tax. For State withholding, use the worksheets on this form, and for federal withholding use the Internal Revenue Service (IRS) Publication 919 or federal withholding calculations.

EXEMPTION FROM WITHHOLDING: If you wish to claim exempt, complete the federal Form W-4. You may claim exempt from withholding California income tax if you did not owe any federal income tax last year and you do not expect to owe any federal income tax this year. The exemption automatically expires on February 15 of the next year. If you continue to qualify for the exempt filing status, a new Form W-4 designating EXEMPT must be submitted before February 15. If you are not having federal income tax withheld this year but expect to have a tax liability next year, the law requires you to give your employer a new Form W-4 by December 1.

**EXEMPTION FROM WITHHOLDING** (continued): Under the Service Member Civil Relief Act, as amended by the Military Spouses Residency Relief Act, you may be exempt from California income tax on your wages if (i) your spouse is a member of the armed forces present in California in compliance with military orders; (ii) you are present in California solely to be with your spouse; and (iii) you maintain your domicile in another state. If you claim exemption under this act, check the box on Line 3. You may be required to provide proof of exemption upon request.

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**IF YOU NEED MORE DETAILED INFORMATION, SEE THE INSTRUCTIONS THAT CAME WITH YOUR LAST CALIFORNIA INCOME TAX RETURN OR CALL THE FRANCHISE TAX BOARD.**

IF YOU ARE CALLING FROM WITHIN THE UNITED STATES (800) 852-5711 (voice)  
(800) 822-6268 (TTY)

IF YOU ARE CALLING FROM OUTSIDE THE UNITED STATES (Not Toll Free) (916) 845-6500

The *California Employer's Guide* (DE 44) provides the income tax withholding tables. This publication may be found on EDD's Web site at [www.edd.ca.gov/Payroll\\_Taxes/Forms\\_and\\_Publications.htm](http://www.edd.ca.gov/Payroll_Taxes/Forms_and_Publications.htm). To assist you in calculating your tax liability, please visit the Franchise Tax Board's Web site at: [www.ftb.ca.gov/individuals/index.shtml](http://www.ftb.ca.gov/individuals/index.shtml).

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**NOTIFICATION:** Your employer is required to send a copy of your DE 4 to the Franchise Tax Board (FTB) if it meets either of the following two conditions:

- You claim more than 10 withholding allowances.
- You claim exemption from State or federal income tax withholding and your employer expects your usual weekly wages to exceed \$200 per week.

IF THE IRS INSTRUCTS YOUR EMPLOYER TO WITHHOLD FEDERAL INCOME TAX BASED ON A CERTAIN WITHHOLDING STATUS, YOUR EMPLOYER IS REQUIRED TO USE THE SAME WITHHOLDING STATUS FOR STATE INCOME TAX WITHHOLDING IF YOUR WITHHOLDING ALLOWANCES FOR STATE PURPOSES MEET THE REQUIREMENTS LISTED UNDER "NOTIFICATION." IF YOU FEEL THAT THE FEDERAL DETERMINATION IS NOT CORRECT FOR STATE WITHHOLDING PURPOSES, YOU MAY REQUEST A REVIEW.

To do so, write to:

W-4 Unit  
Franchise Tax Board MS F180  
P.O. Box 2952  
Sacramento, CA 95812-2952  
Fax: (916) 843-1094

Your letter should contain the basis of your request for review. You will have the burden of showing the federal determination incorrect for State withholding purposes. The Franchise Tax Board (FTB) will limit its review to that issue. The FTB will notify both you and your employer of its findings. Your employer is then required to withhold State income tax as instructed by FTB. In the event FTB or IRS finds there is no reasonable basis for the number of withholding exemptions that you claimed on your Form W-4/DE 4, you may be subject to a penalty.

**PENALTY:** You may be fined \$500 if you file, with no reasonable basis, a DE 4 that results in less tax being withheld than is properly allowable. In addition, criminal penalties apply for willfully supplying false or fraudulent information or failing to supply information requiring an increase in withholding. This is provided for by Section 19176 of the California Revenue and Taxation Code.

**DWC FORM 9783 (March 1, 2007) PREDESIGNATION OF PERSONAL PHYSICIAN**

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

- your employer offers group health coverage;
- the doctor is your regular physician, who shall be either a physician who has limited his or her practice of medicine to general practice or who is a board-certified or board-eligible internist, pediatrician, obstetrician-gynecologist, or family practitioner, and has previously directed your medical treatment, and retains your medical records;
- your "personal physician" may be a medical group if it is a single corporation or partnership composed of licensed doctors of medicine or osteopathy, which operates an integrated multispecialty medical group providing comprehensive medical services predominantly for nonoccupational illnesses and injuries;
- prior to the injury your doctor agrees to treat you for work
- prior to the injury your doctor agrees to treat you for work injuries or illnesses;
- prior to the injury you provided your employer the following in writing: (1) notice that you want your personal doctor to treat you for a work-related injury or illness, and (2) your personal doctor's name and business address.

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

<b>EMPLOYEE</b>	
You (the employee) sign this section.	
<b>Employer</b>	_____
<b>Employee Name*</b>	_____
<b>SS#*</b>	_____
<b>(Alternate ID)</b>	_____
<b>Date of Hire</b>	_____
<b>Date of Birth</b>	_____
<b>Address</b>	_____
<b>City</b>	_____
<b>St, Zip</b>	_____
In the event of any on-the-job, work-related injury, I request that I be treated by my personal physician.	
<b>Signature</b>	<u>  X  </u> _____
<b>Date</b>	_____

<b>PHYSICIAN</b>	
We cannot process this form without the fields marked bold with an asterisk.	
Please PRINT clearly. _____	
<b>Physician First Name*</b>	_____
<b>Physician Last Name*</b>	_____
<b>Street Address*</b>	_____
of the physician's practice	_____
<b>City*</b>	_____
<b>St, Zip*</b>	_____
Telephone Number of the physician's practice	(    )    -    _____
Group Name:	_____
CA License	_____
I agree to this Predesignation:	
<b>Physician Signature</b>	<u>  X  </u> _____
<b>Date of Acceptance</b>	_____

The physician is not required to sign this form, however, if the physician or designated employee of the physician does not sign, other documentation of the physician's agreement to be predesignated will be required pursuant to Title 8, California Code of Regulations, section 9780.1(a)(3).

**Completed forms should be returned to  
<Employer>**

**ACKNOWLEDGEMENT OF RECEIPT**

**MEDICAL PROVIDER NETWORK AND EMPLOYEE  
PREDESIGNATION**

By signing below, I acknowledge that I have been provided with the Important Notification regarding \_\_\_\_\_ School District's Medical Provider Network (MPN) for treatment of work-related injuries only.

I understand that if I have any questions regarding this letter, I can contact the MPN Designee as indicated on the letter for additional information.

\_\_\_\_\_  
Employee Name

\_\_\_\_\_  
Date Received

\_\_\_\_\_  
Date of Hire

*For district use only:*

*MPN letter provided to employee by:*

\_\_\_\_\_  
*Employee name*

\_\_\_\_\_  
*Date*

## Important Notification

### UNDERSTANDING YOUR RIGHTS AS AN INJURED WORKER

**IF YOU DO NOT UNDERSTAND ANY PART OF THIS NOTIFICATION, CONTACT HUMAN RESOURCES DEPARTMENT FOR HELP IN UNDERSTANDING YOUR RIGHTS.**

North Bay Schools Insurance Authority has arranged for a Medical Provider Network (MPN) This MPN has been designed to **ensure immediate quality care** in the event of a workplace injury. Your contact for this Workers' Compensation Program is Diane Matthews who is the MPN designee at Network HCO at (562) 546-0035 or (888) 499-9643.

#### DESCRIPTION OF MPN SERVICE

An MPN is any entity or group of providers approved by the Administrative Director for the State of California, Division of Workers' Compensation. The MPN is made up of primary care physicians and facilities for medical treatment and services. These providers will work with you and your employer to ensure a smooth and safe return to work.

The MPN is composed of providers and facilities that are geographically available to all employees. As a covered employee, you will have access to a primary care physician and a hospital for emergency health care services within 30 minutes or 15 miles of your residence or workplace. Your MPN also has providers of occupational health services and specialists within 60 minutes or 30 miles of your residence or workplace.

#### HOW TO REVIEW, RECEIVE OR ACCESS THE ENTIRE MPN PROVIDER DIRECTORY

Request a disk by calling 888/499-9643.

Log on to MPN website at [www.networkhco.com](http://www.networkhco.com).

#### ACCESSING INITIAL AND SUBSEQUENT CARE

- **In a life threatening or emergency situation call 911.**
  - "Emergency Health Care Services" or "Urgent Care" is defined as health care services for a medical condition manifesting itself by acute symptoms of sufficient severity such that the absence of immediate medical attention could reasonably be expected to place patient's health in serious jeopardy.
- Notify your employer immediately. The district has made arrangements to work with local clinics.
- After your initial doctor's visit, you may continue with the initial treating physician, or you may select another physician from within the MPN.
- After-hours and out-of-area injuries should be treated at the closest medical service or hospital provider (including Emergency Room), even if they are not members of the MPN. You should notify your District Workers' Compensation Coordinator of the injury as soon as reasonably possible.
- After your initial MD visit, the MPN designee will contact you to answer any questions.
- If you have trouble getting an appointment for non-emergency services with an MPN physician within 3 business days or an MPN specialist within 20 business days of reporting your injury or illness, you should call your MPN designee.

## HOW TO CHOOSE A PHYSICIAN WITHIN THE MPN

You have the right to change your doctor and select another doctor from within the MPN. You may choose from the entire MPN by:

- Request a disk by calling 888/499-9643;
- Log on to MPN website at [www.networkhco.com](http://www.networkhco.com).

## HOW TO OBTAIN A REFERRAL TO A SPECIALIST

If the nature of your injury/illness requires a specialist, your doctor and your MPN designee will work with you to schedule an appointment with a specialist in your geographic area.

## HOW TO USE THE 2<sup>ND</sup> AND 3<sup>RD</sup> OPINION PROCESS

If you disagree with either the diagnosis or treatment prescribed by the Primary Treating Physician or your treating physician, you may obtain a 2<sup>nd</sup> and 3<sup>rd</sup> opinion from within the MPN. During this process you are required to continue your treatment with the treating physician or a physician of his or her choice.

### 2<sup>nd</sup> opinion process

It is your responsibility to:

1. Inform the MPN or person designated by the MPN that you dispute the treating physician's opinion and request a 2<sup>nd</sup> opinion.
2. Select a physician or specialist from a list of available MPN providers
3. Make an appointment with the second opinion physician within 60 days.
4. Inform the MPN designee of the appointment date.

It is the MPN designee's responsibility to:

1. Provide a list of MPN providers and/or specialists for your selection based on the specialty or recognized expertise in treating the particular injury or condition in question.
2. Contact the treating physician, provide a copy of the medical records or send the necessary medical records to the 2<sup>nd</sup> opinion physician prior to the appointment date, and provide a copy of the records to the covered employee upon request.
3. Notify the 2<sup>nd</sup> opinion physician in writing that he or she has been selected to provide a second opinion and the nature of the dispute with a copy to you.
4. The MPN designee will also communicate with the 2<sup>nd</sup> opinion physician to ensure that the providers are working within the appropriate timeframes.

### 3<sup>rd</sup> Opinion Process

It is your responsibility to:

1. Inform the MPN or person designated by the MPN that you dispute the treating physician's opinion and request a 3<sup>rd</sup> opinion.
2. Select a physician or specialist from a list of available MPN providers.
3. Make an appointment with the 3<sup>rd</sup> opinion physician within 60 days.
4. Inform the MPN designee of the appointment date.

It is the MPN designee's responsibility to:

1. Provide a list of MPN providers and/or specialists for your selection based on the specialty or recognized expertise in treating the particular injury or condition in question.

2. Contact the treating physician, provide a copy of the medical records or send the necessary medical records to the 2<sup>nd</sup> opinion physician prior to the appointment date, and provide a copy of the records to the covered employee upon request.
3. Notify the 3<sup>rd</sup> opinion physician in writing that he or she has been selected to provide a 3<sup>rd</sup> opinion and the nature of the dispute with a copy to you.
4. The MPN designee will also communicate with the 3<sup>rd</sup> opinion physician to ensure that the providers are working within the appropriate timeframes.
5. Notify you about the Independent Medical Review Process and also provide you with the Application for Independent Medical Review (IMR) form.

### HOW TO OBTAIN AN INDEPENDENT MEDICAL REVIEW (IMR)

If you disagree with the diagnostic services, diagnosis or medical treatment prescribed by the 2<sup>nd</sup> or 3<sup>rd</sup> opinions you may file a request for an Independent Medical Review with the Administrative Director.

You must fill out the employee section of the form which was sent to you when the 3<sup>rd</sup> opinion physician was selected. (If you need another copy, the MPN designee can provide you with another copy.) Be sure to indicate on the form if you are requesting an in person exam or a records review.

The MPN designee will gather all information pertaining to your disputed treatment or diagnostic services. All correspondence and medical records received from any treating physician involved in your case will be forwarded to the IMR.

You will receive a written notice of the name of the IMR from the Administrative Director. Notice will also be sent to the IMR, MPN designee and your attorney (if applicable).

If there is a conflict of interest, either party can object to the selection. If conflict is verified the Administrative Director will select another IMR from the same specialty.

You must schedule an appointment within 60 calendar days of receiving the name of the IMR.

If you decide to withdraw your request for an IMR, you must provide written notice to the Administrative Director and the MPN designee.

*During this process you are required to continue your treatment within the MPN.*

### TRANSFER OF ONGOING CARE INTO THE MPN

If you have an open Workers' Compensation claim, your claim may be transferred into the MPN. Your claim will be individually evaluated for possible inclusion. Once a determination is made regarding your claim status, you and your Primary Treating Physician will be notified in writing whether the claim will be transferred into the MPN.

If the decision is to keep your claim out of the MPN, then you will be allowed to continue your care with your current Primary Treating Physician. The following are the most common reasons why your claim may not be included in the MPN:

- Your condition is *acute* and involves a sudden onset of symptoms due to illness, injury or other medical problem that requires prompt medical treatment and should be resolved with no more than 30 days treatment.
- Your condition is *serious and chronic* and is due to a disease, illness, catastrophic injury or other medical problem or disorder. It must be serious and persist without full cure or worsen over 90 days and require ongoing treatment to maintain remission or prevent deterioration. Completion of your treatment outside the MPN will be authorized for a period of up to one year.
- Your illness is *terminal* and is considered to be an incurable or irreversible condition that has a high probability of causing death within one year or less. All treatment will be provided for the duration of your illness.
- You have already been authorized, as part of your documented treatment, to have surgery or another procedure within 180 days from the MPN coverage effective date.

If you dispute our determination regarding inclusion into the MPN, you have the right to request a report from your Primary Treating Physician. He/She will be asked to address whether or not you fall into one of the above-noted conditions, thereby precluding your claim inclusion.

If you or your District representative objects to the medical determination of the treating physician regarding the transfer of care decision, either side has the right to have their objection heard by the Workers' Compensation Appeals Board.

If the treating physician agrees with the determination regarding the transfer, then the transfer of care shall go forward during the dispute process. However, if the treating physician does not agree with the determination, then the transfer of care into the MPN shall go forward until the dispute process is resolved.

#### **CONTINUITY OF CARE**

Depending on defined circumstances, continuity of care will be provided for up to twelve months even after the provider leaves the network. This rule is applicable for acute conditions, a serious chronic condition, a terminal illness or performance of surgery or other procedure that is authorized by insurer or employer. See attached Continuity of Care Policy for full details.

#### **PLEASE NOTE**

**IN AN EMERGENCY, IT IS IMPORTANT THAT YOU RECEIVE IMMEDIATE MEDICAL ATTENTION FROM A MEDICAL SERVICE OR HOSPITAL PROVIDER, INCLUDING THOSE FACILITIES OR PROVIDERS THAT ARE NOT MEMBERS OF THE MPN!**

Attachments: Continuity of Care Policy



# APPLE

(ACCUMULATION PROGRAM FOR PART-TIME AND LIMITED-SERVICE EMPLOYEES)

## What is APPLE?

- An alternate to Social Security to comply with the regulations of Internal Revenue Code 3121
- A Qualified Plan under IRC 401(a) or 457(b) for part-time and limited service employees
- Employees are eligible if not covered under PERS/STRS or bargaining agreement precluding coverage

## APPLE Benefits

- Combined employee/employer contribution equals 7.5% of the employee's compensation.
- Pre-tax contribution provides increased take home pay now and additional retirement income later.
- Full guarantee of principal in Group Annuity Contract and a guaranteed 3% minimum interest rate.
- No annual, administration or distribution fees. (Declared interest rate is net of Plan costs).
- Participant is always 100% vested.
- Distributions are paid quarterly and 'Requests for Settlement of Account' are submitted to MidAmerica
- Benefits are based on participant's selection of either a single lump sum payment or a direct rollover.
- Money Purchase Plan funds (MPP) are not available for distribution until termination of employment or age 70 ½. For more information, please call Customer Service at 800-634-1178.
- Monthly valuations with full cash accounting provide consistent statement and plan balancing.
- Annual 'Statements of Account' are mailed directly to each participant after each Fiscal Year end.
- A Plan Document and Summary Plan Description is prepared for each Employer.

## APPLE - Beneficiary Designation

- The beneficiary will automatically be the participant's spouse if married, or their estate if not married. Participant's may designate a beneficiary of their choice by completing a Beneficiary Designation or Participant Data Change Form. If you are married, you MUST have your spouse's written consent if you want to designate someone else as your beneficiary.

## APPLE Website

- Beginning March 1, 2004, the APPLE Plan Website will allow Plan participants and Plan Sponsors to;
  - perform participant account level inquiry,
  - perform participant name and address changes,
  - 'model', view and print participant 'Statements of Account' and 'Transaction History Reports',
  - print processing request forms; such as Settlement of Account and Beneficiary Designation Forms
  - 'model', view and print Plan Sponsor Valuation Reports

## APPLE Team

**Consultant**  
Keenan & Associates

- Coordinates services between ING and MidAmerica
- Assists the District in implementing the Plan
- Acts as Consultant to the District for Plan services
- Provides information and direction for the Plan

**Keenan & Associates**

**Contract Administrator**  
MidAmerica Administrative Solutions

  
**MidAmerica**  
Administrative Solutions, Inc.

- Resource for all participant questions
- Maintains Plan records
- Produces 'Statements' & 'Valuations'
- Mails distributions and refunds

**APPLE PLAN**

**Funding Company**  
ReliaStar Life Insurance Company,  
a member of ING

- A.M. Best rates A+ Superior,
- Group Annuity Contract Underwriter

**ING** 

**MAILING ADDRESS:** MidAmerica, Attn: APPLE, 211 E. Main Street, Suite 100, Lakeland, FL 33801

Fax: 863-686-9727, Email: [info@midamerica.biz](mailto:info@midamerica.biz) (Subject line: APPLE Plan)

Form IFEW03032004

**WEBSITE** [www.keenanassoc.com](http://www.keenanassoc.com)

**APPLE PLAN CUSTOMER SERVICE 800.634.1178**

# Beneficiary Designation or Participant Data Change Form – APPLE PLAN

Please complete this form if you would like to designate your beneficiary.  
Otherwise, your beneficiary will automatically be your spouse if you are married, or your estate if you are not married.

Your Employer: \_\_\_\_\_

**CHECK ONE:**

Beneficiary Designation or Beneficiary Change       Address Change       Name Change

**1. PARTICIPANT INFORMATION:** *This section must be completed.*

Employee Name (Last, First, Middle) \_\_\_\_\_ Male  Female

Home Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Social Security # \_\_\_\_\_ Date of Birth \_\_\_\_\_ Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

**2. BENEFICIARY DESIGNATION:** *This section must be completed to change beneficiary.*

I am married and designate the following person(s) to receive death benefits from the Plan.

Primary Beneficiary Name\*: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ SS#: \_\_\_\_\_

Contingent Beneficiary Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ SS#: \_\_\_\_\_

**SPOUSAL CONSENT**

I CONSENT TO THIS DESIGNATION THAT ELIMINATES ALL OR PART OF THE BENEFITS OTHERWISE PAYABLE TO ME FROM THE PLAN IF MY SPOUSE DIES.

\_\_\_\_\_  
Spouse Consent Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Notary Public or Employer

**3. NAME CHANGE:**

From: \_\_\_\_\_ To: \_\_\_\_\_

Reason for Change:     Marriage     Divorce     Other:

**4. SIGNATURES:** *This section must be completed.*

Participant's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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

EMPLOYEE -- Forward this form to: MidAmerica Administrative Solutions, 211 East Main Street, Suite 100, Lakeland, FL 33801  
Or fax to: 863-686-9727