Certificated New Hire Guide:

This document is only a guide to help you with the new hire paperwork that is required/necessary to begin the hiring process. Should you have any questions please contact the Human Resources Department at (559) 834-6083.

**Fingerprints** – You must be fingerprinted at the Fresno County Office of Education prior to employment. A Human Resources Representative will assist you in scheduling a fingerprint appointment.

**ITEMS REQUIRED TO PRESENT WHEN TURNING IN PACKET**

- **Driver’s License** – We need a valid driver’s license.

- **Social Security Card** – We need your original social security card in order to pay you. Your payroll check will be issued using the name on your social security card.

- **Transcripts** – Receipt of official transcripts verifying the number of units beyond your BA or BS degree are required within 30 days of signing your contract. This is used to compute your placement on the salary schedule. Copies are accepted prior to official transcripts being received.

- **Credentials** – We require a copy of your credential(s). All credentials must also be on file at FCOE Credentials Office.

**EMPLOYEE INFORMATION FORMS**

- **Employee Information Form & Contact Notice** – This form is to let certain district personnel know how to get in contact with you by mail or telephone. Please let us know if this information can also be given to fellow employees or parents.

- **Previous Work Experience and Sick Leave Transfer Request** – If you previously worked in a California public school and you want to transfer your accumulated sick leave from your prior district and previous teaching experience verification. Please do NOT add your previous employer name.

- **Federal Race and Ethnicity Data Collection** – Optional. School Districts are required to collect data regarding employee race and ethnicity required by the Equal Employment Commission.

- **Employment Eligibility Verification (I-9)** – Complete the top portion and sign. Please review form for appropriate supporting documentation.

- **W-4 & DE-4** – This is to let the district know how much income tax withholding is to be retained from your wages and sent to the Internal Revenue Service and Franchise Tax Board. You must complete your name in box 1, your social security number in box 2, your filing status in box 3, your exemptions in box 5, and your signature. The California PIT Withholding (DE-4) is for your state withholding.

- **Deduct Overpayment Authorization Form** – In the event an overpayment in salary is made in error, Fowler Unified can recover the overpayment through a payroll deduction at the time the overpayment is discovered. This form is affective for the duration of employment with the District.
Tuberculosis Test (TB) – The law requires verification of a negative TB skin test or X-ray taken within the last 60 days. However, if you are transferring from another school district, the previous school district can instead provide verification of a negative TB test within the last four years.

Certificate of Medical Examination – The form is to be completed by all individuals who are accepting a teaching position for the first time in California. This form is to be printed out and completed by a medical provider. This is a required form for all first time teachers in California.

CALPERS Notice of Exclusion Membership Form – Please complete, sign and return to the Human Resources Department. This helps identify based on the criteria on the form and in your position you are excluded from CALPERS membership.

CALPERS Reciprocal Self Certification Form – Please complete, sign and return to the Human Resources Department. This form is your self-certification that you have or have not been a member of a qualifying public retirement system in California.

CALSTRS Crossover Election Form ES-372 – This form is to be completed if you have been or currently are a member of CalPERS. On this form you indicate your willingness to remain in CalPERS or declare your intention to enroll in CalSTRS. This form must be completed and returned within 60 days of employment. This is a required form if you have previous or current membership in CalPERS.

CALSTRS Permissive Membership Form ES-350 – This form is used to permissively elect membership in the CalSTRS defined benefit program and/or to acknowledge receipt of information provided by an employer about the right to elect membership in the CalSTRS defined benefit program. Please read all instructions before completing the form.

EMPLOYEE POLICIES & ACKNOWLEDGMENTS

Annual and Mandated Notices – You are signing receipt, read, acknowledgment, and understanding of the HR Orientation, Notices, Manuals, Handbook, Policies, Procedures, etc. Sign and return acknowledgement. [https://www.fowlerusd.org/Page/4051](https://www.fowlerusd.org/Page/4051)

Mandated Reporter Acknowledgement Form - This form is required by law, verifying each employee understands his or her responsibility in reporting child abuse.

Drug and Alcohol-Free Workplace Notice – Receipt of this notice must be signed and returned.

Employee Use of Technology Agreement (BP 4040) – Receipt of this notice must be signed and returned.

Oath or Affirmation – By signing this form, you are swearing or affirming your allegiance to the United States as required by law. Please read, sign, and date this form.

Statement Concerning Your Employment in a Job Not Covered by Social Security – This statement explains how a STRS pension could affect future Social Security benefits to which you may become entitled.

OPTIONAL FORMS

Automatic Pay Deposit – Your check can be electronically deposited to your bank. This form will be provided upon request.
CALSTRS Recipient Designation – This form is a beneficiary designation form for your CalSTRS retirement monies. This is an optional form for those selecting CalSTRS membership. Although this is an optional form, it is highly recommended that this form be on file with CalSTRS if you are a member. Form is available upon request.

Employer Notification of Personal Physician – If you were to be injured on the job, you would be required to go to one of the district’s many appointed workers comp physician. The list of workers comp doctors is available from the Human Resources Department. If you would like to go to your own physician, you need to complete this form and return it to the District Office before an injury. Click Here to view the Predesignation of Personal Physician Form.

ADDITIONAL RESOURCES

District Calendar – The calendar shows your required workdays and can be found on the district website.

CalSTRS Information – Additional information on CalSTRS can be found on www.calstrs.ca.gov and Click Here to view CalSTRS Information.
Employee Information and Contact Notice

☐ New Employee  ☐ Volunteer  ☐ Emergency Contact Change  ☐ Address Change or Phone Number Change
☐ Name Change (If this box is checked, A new Social Security Card must be provided in person to change your name)

PLEASE PRINT

Employee Name: _______________________________ Date: _______________

New Name: _______________________________ Last 4 of SSN: _____________

Personal Email: _____________________________________________________

Current Address:

Street                                  City          State          Zip

Other/New Address: (If your primary address is a P.O. Box, please list your physical address here)

Street                                  City          State          Zip

Primary Phone: (  )______________________ Other Phone: (  )______________________

Marital Status: __________________________ Date of Birth: ______________________

Person(s) to contact in case of an emergency. (Include at least one relative)

<table>
<thead>
<tr>
<th>Name</th>
<th>Home Phone</th>
<th>Cell Phone</th>
<th>Work Phone</th>
<th>Relationship</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Employee Signature: ____________________________________________

Date: ___________________________________________________________

Department/Site: _______________________________________________

Office Use Only:
Date Entered: _______________

Return Completed Form to the Human Resources Department
658 East Adams Avenue
Fowler, CA 93525

Rev. 09/2021
# VERIFICATION OF PREVIOUS TEACHING EXPERIENCE

Fowler Unified School District  
Human Resources Department 658 E. Adams Avenue  
Fowler, California 93625  
Phone: (559) 834-6083; Fax: (559) 834-3390

Date: __________________________

School District: ____________________________________________________________

The following individual has been recently employed by the Fowler Unified School District:

Name: ____________________________________________ SSN: XXX-XX-__________

Former Name(s): __________________________________________________________

Records indicate that this individual was employed in your district prior to being hired by Fowler Unified. We would appreciate your help in supplying the information requested below so that we may transfer experience and/or accumulated sick leave credit in compliance with Section 13468 of the California Education Code. Please complete the previous teaching experience information requested below and return it to us at your earliest convenience.

I hereby authorize release of the information requested below:

________________________________________________________________________

Employee Signature Date

# VERIFICATION OF EXPERIENCE:

This will verify that the above named individual was employed in this district as follows:

Position/Job Title: ____________________________________________ from ___ / ___ / ___ to ___ / ___ / ___ for a total of _____ school year(s).

The service was: [ ] Full-time [ ] Part-time

If "part-time," please define (indicate fraction of time or total days served): ________________________________

# CALIFORNIA DISTRICTS ONLY: VERIFICATION OF ACCUMULATED DAYS OF LEAVE OF ABSENCE FOR ILLNESS OR INJURY

Our records indicate that the above-named individual was entitled to a total of __________ hours of accumulated unused sick leave upon termination of employment with this district (California Education Code section 44979).

School District: ____________________________________________________________

Address: ______________________________________________________________________

Name of Authorized Personnel (Please Print): ___________________________ Title: ______________________

Signature of Authorized Personnel: ____________________________ Date: _____ / _____ / _____

Email: _______________________________ Phone #: ______________________________

Rev. 09.2021
Federal Race and Ethnicity Data Collection  
(Voluntary)

School districts are required to collect data regarding employee race and ethnicity. All individuals are requested to complete this form in order to comply with federal and state mandated reporting. Your response will be kept confidential. There is no "unknown" or "decline to state" reporting allowed. If the respondent does not self-identify, the California Department of Education will report such respondents in the category of "two or more races" unless the respondent has already marked Hispanic or Latino for ethnicity.

<table>
<thead>
<tr>
<th>Name:</th>
<th>Position:</th>
<th>Today’s Date:</th>
</tr>
</thead>
</table>

**ETHNIC ORIGIN**  
(Please check only one with which you most closely identify)

- Cuban (05)  
- Hispanic American (04)  
- Puerto Rican (07)  
- Central or South American (08)  
- Other Spanish (09)  

-OR-

- Not Hispanic or Latino

**RACE**  
(No matter what you selected above, please continue to answer the following by marking one or more boxes to indicate what you consider to be your race)

- American Indian or Alaskan Native (03)
- Chinese (11)
- Filipino (13)
- Far East/India (14)
- Other Asian (25)
- Hawaiian (16)
- Tahitian (22)
- Black or African American (02)

- Cambodian (12)
- Japanese (18)
- Korean (19)
- Other Pacific Islander (24)
- Guamanian (15)

- Hmong (17)
- Vietnamese (23)
- Laotian (20)

**GENDER:**

- Male
- Female
- Nonbinary

**AGE CATEGORY:**

- 18 - 24
- 25 - 35
- 36-44
- 45 - 55
- 56-64
- 65 and over

**DISABILITIES:**

Do you have any condition for which you need accommodation in order to perform the essential functions of this position?  
- Yes
- No

**VETERAN STATUS:**

- Not a Veteran (01)
- Vietnam-era Veteran (02)
- Disabled Vietnam-era Veteran (03)
- Veteran (04)

**NOTICE OF NONDISCRIMINATION:**

The Fowler Unified School District does not discriminate on the basis of race, color, sex, disability, or national origin in admission or access to and treatment of employment in its programs and activities as required by Title VI, Title IX, and Section (504).

Revised: 3.2018
**START HERE:** Read instructions carefully before completing this form. The instructions must be available, either in paper or electronically, during completion of this form. Employers are liable for errors in the completion of this form.

**ANTI-DISCRIMINATION NOTICE:** It is illegal to discriminate against work-authorized individuals. Employers CANNOT specify which document(s) an employee may present to establish employment authorization and identity. The refusal to hire or continue to employ an individual because the documentation presented has a future expiration date may also constitute illegal discrimination.

### Section 1. Employee Information and Attestation

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

<table>
<thead>
<tr>
<th>Last Name (Family Name)</th>
<th>First Name (Given Name)</th>
<th>Middle Initial</th>
<th>Other Last Names Used (if any)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Address (Street Number and Name)</th>
<th>Apt. Number</th>
<th>City or Town</th>
<th>State</th>
<th>ZIP Code</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Date of Birth (mm/dd/yyyy)</th>
<th>U.S. Social Security Number</th>
<th>Employee’s E-mail Address</th>
<th>Employee’s Telephone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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 boxes):

1. A citizen of the United States
2. A noncitizen national of the United States (See instructions)
3. A lawful permanent resident (Alien Registration Number/USCIS Number): ___________________________
   Some aliens may write “N/A” in the expiration date field. (See instructions)
4. An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy): ______________________
   Aliens authorized to work must provide only one of the following document numbers to complete Form I-9:
   An Alien Registration Number/USCIS Number OR Form I-94 Admission Number OR Foreign Passport Number.
   1. Alien Registration Number/USCIS Number: ___________________________
   OR
   2. Form I-94 Admission Number: ___________________________
   OR
   3. Foreign Passport Number: ___________________________
   Country of Issuance: ___________________________

<table>
<thead>
<tr>
<th>Signature of Employee</th>
<th>Today’s Date (mm/dd/yyyy)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Preparer and/or Translator Certification (check one):

☐ I did not use a preparer or translator. ☐ A preparer(s) and/or translator(s) assisted the employee in completing Section 1.

*(Fields below must be completed and signed when preparers and/or translators assist an employee in completing Section 1.)*

I attest, under penalty of perjury, that I have assisted in the completion of Section 1 of this form and that to the best of my knowledge the information is true and correct.

<table>
<thead>
<tr>
<th>Signature of Preparer or Translator</th>
<th>Today’s Date (mm/dd/yyyy)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Last Name (Family Name)</th>
<th>First Name (Given Name)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Address (Street Number and Name)</th>
<th>City or Town</th>
<th>State</th>
<th>ZIP Code</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Section 2. Employer or Authorized Representative Review and Verification

(Employers or their authorized representative must complete and sign Section 2 within 3 business days of the employee’s first day of employment. You must physically examine one document from List A OR a combination of one document from List B and one document from List C as listed on the "Lists of Acceptable Documents.")

<table>
<thead>
<tr>
<th>Employee Info from Section 1</th>
<th>Last Name (Family Name)</th>
<th>First Name (Given Name)</th>
<th>M.I.</th>
<th>Citizenship/Immigration Status</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>List A</th>
<th>OR</th>
<th>List B</th>
<th>AND</th>
<th>List C</th>
</tr>
</thead>
<tbody>
<tr>
<td>Document Title</td>
<td>Document Title</td>
<td>Document Title</td>
<td>Document Title</td>
<td>Document Title</td>
</tr>
<tr>
<td>Issuing Authority</td>
<td>Issuing Authority</td>
<td>Issuing Authority</td>
<td>Issuing Authority</td>
<td>Issuing Authority</td>
</tr>
<tr>
<td>Document Number</td>
<td>Document Number</td>
<td>Document Number</td>
<td>Document Number</td>
<td>Document Number</td>
</tr>
<tr>
<td>Expiration Date (if any) (mm/dd/yyyy)</td>
<td>Expiration Date (if any) (mm/dd/yyyy)</td>
<td>Expiration Date (if any) (mm/dd/yyyy)</td>
<td>Expiration Date (if any) (mm/dd/yyyy)</td>
<td>Expiration Date (if any) (mm/dd/yyyy)</td>
</tr>
<tr>
<td>Document Title</td>
<td>Document Title</td>
<td>Document Title</td>
<td>Document Title</td>
<td>Document Title</td>
</tr>
<tr>
<td>Issuing Authority</td>
<td>Issuing Authority</td>
<td>Issuing Authority</td>
<td>Issuing Authority</td>
<td>Issuing Authority</td>
</tr>
<tr>
<td>Document Number</td>
<td>Document Number</td>
<td>Document Number</td>
<td>Document Number</td>
<td>Document Number</td>
</tr>
<tr>
<td>Expiration Date (if any) (mm/dd/yyyy)</td>
<td>Expiration Date (if any) (mm/dd/yyyy)</td>
<td>Expiration Date (if any) (mm/dd/yyyy)</td>
<td>Expiration Date (if any) (mm/dd/yyyy)</td>
<td>Expiration Date (if any) (mm/dd/yyyy)</td>
</tr>
<tr>
<td>Additional Information</td>
<td></td>
<td></td>
<td></td>
<td>QR Code - Sections 2 &amp; 3 Do Not Write In This Space</td>
</tr>
</tbody>
</table>

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

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

<table>
<thead>
<tr>
<th>Signature of Employer or Authorized Representative</th>
<th>Today's Date (mm/dd/yyyy)</th>
<th>Title of Employer or Authorized Representative</th>
</tr>
</thead>
<tbody>
<tr>
<td>Last Name of Employer or Authorized Representative</td>
<td>First Name of Employer or Authorized Representative</td>
<td>Employer's Business or Organization Name</td>
</tr>
<tr>
<td>Fowler Unified School District</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Employer's Business or Organization Address (Street Number and Name)
658 E. Adams Ave

City or Town
Fowler

State
CA
ZIP Code
93625

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

A. New Name (if applicable)

<table>
<thead>
<tr>
<th>Last Name (Family Name)</th>
<th>First Name (Given Name)</th>
<th>Middle Initial</th>
<th>Date (mm/dd/yyyy)</th>
</tr>
</thead>
</table>

B. Date of Rehire (if applicable)

<table>
<thead>
<tr>
<th>Date (mm/dd/yyyy)</th>
</tr>
</thead>
</table>

C. If the employee's previous grant of employment authorization has expired, provide the information for the document or receipt that establishes continuing employment authorization in the space provided below.

<table>
<thead>
<tr>
<th>Document Title</th>
<th>Document Number</th>
<th>Expiration Date (if any) (mm/dd/yyyy)</th>
</tr>
</thead>
</table>

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.

<table>
<thead>
<tr>
<th>Signature of Employer or Authorized Representative</th>
<th>Today's Date (mm/dd/yyyy)</th>
<th>Name of Employer or Authorized Representative</th>
</tr>
</thead>
</table>
LISTS OF ACCEPTABLE DOCUMENTS

All documents must be UNEXPIRED

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

<table>
<thead>
<tr>
<th>LIST A</th>
<th>LIST B</th>
<th>LIST C</th>
</tr>
</thead>
<tbody>
<tr>
<td>Documents that Establish</td>
<td>Documents that Establish</td>
<td>Documents that Establish</td>
</tr>
<tr>
<td>Both Identity and</td>
<td>Identity</td>
<td>Employment Authorization</td>
</tr>
<tr>
<td>Employment Authorization</td>
<td></td>
<td></td>
</tr>
<tr>
<td>OR</td>
<td>AND</td>
<td></td>
</tr>
<tr>
<td>1. U.S. Passport or U.S. Passport Card</td>
<td>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</td>
<td>1. A Social Security Account Number card, unless the card includes one of the following restrictions:</td>
</tr>
<tr>
<td>2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)</td>
<td>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</td>
<td>(1) NOT VALID FOR EMPLOYMENT</td>
</tr>
<tr>
<td>3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa</td>
<td></td>
<td>(2) VALID FOR WORK ONLY WITH INS AUTHORIZATION</td>
</tr>
<tr>
<td>4. Employment Authorization Document that contains a photograph (Form I-766)</td>
<td>3. School ID card with a photograph</td>
<td>(3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION</td>
</tr>
<tr>
<td>5. For a nonimmigrant alien authorized to work for a specific employer because of his or her status:</td>
<td>4. Voter's registration card</td>
<td>2. Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240)</td>
</tr>
<tr>
<td>a. Foreign passport; and</td>
<td>5. U.S. Military card or draft record</td>
<td></td>
</tr>
<tr>
<td>b. Form I-94 or Form I-94A that has the following:</td>
<td>6. Military dependent's ID card</td>
<td>3. Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal</td>
</tr>
<tr>
<td>(1) The same name as the passport; and</td>
<td>7. U.S. Coast Guard Merchant Mariner Card</td>
<td>4. Native American tribal document</td>
</tr>
<tr>
<td>(2) An endorsement of the alien's nonimmigrant status as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form.</td>
<td>8. Native American tribal document</td>
<td>5. U.S. Citizen ID Card (Form I-197)</td>
</tr>
<tr>
<td>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</td>
<td>9. Driver's license issued by a Canadian government authority</td>
<td>6. Identification Card for Use of Resident Citizen in the United States (Form I-179)</td>
</tr>
</tbody>
</table>

For persons under age 18 who are unable to present a document listed above:

| 10. School record or report card |
| 11. Clinic, doctor, or hospital record |
| 12. Day-care or nursery school record |

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

Refer to the instructions for more information about acceptable receipts.
Form W-4

Employee’s Withholding Certificate

Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay.

Give Form W-4 to your employer.

Your withholding is subject to review by the IRS.

---

Step 1: Enter Personal Information

<table>
<thead>
<tr>
<th>(a) First name and middle initial</th>
<th>Last name</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Address

City or town, state, and ZIP code

(c) □ Single or Married filing separately
    □ Married filing jointly or Qualifying surviving spouse
    □ Head of household (Check only if you’re unmarried and pay more than half the costs of keeping up a home for yourself and a qualifying individual)

Does your name match the name on your social security card? If not, to ensure you get credit for your earnings, contact SSA at 800-772-1213 or go to www.ssa.gov.

---

Step 2: Multiple Jobs or Spouse Works

Complete this step if you (1) hold more than one job at a time, or (2) are married filing jointly and your spouse also works. The correct amount of withholding depends on income earned from all of these jobs.

Do only one of the following.

(a) Reserved for future use.

(b) Use the Multiple Jobs Worksheet on page 3 and enter the result in Step 4(c) below; or

(c) If there are only two jobs total, you may check this box. Do the same on Form W-4 for the other job. This option is generally more accurate than (b) if pay at the lower paying job is more than half of the pay at the higher paying job. Otherwise, (b) is more accurate.

TIP: If you have self-employment income, see page 2.

---

Step 3: Claim Dependent and Other Credits

If your total income will be $200,000 or less ($400,000 or less if married filing jointly):

Multiply the number of qualifying children under age 17 by $2,000

Multiply the number of other dependents by $500

Add the amounts above for qualifying children and other dependents. You may add to this the amount of any other credits. Enter the total here.

---

Step 4 (optional): Other Adjustments

(a) Other income (not from jobs). If you want tax withheld for other income you expect this year that won’t have withholding, enter the amount of other income here. This may include interest, dividends, and retirement income.

(b) Deductions. If you expect to claim deductions other than the standard deduction and want to reduce your withholding, use the Deductions Worksheet on page 3 and enter the result here.

(c) Extra withholding. Enter any additional tax you want withheld each pay period.

---

Step 5: Sign Here

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

Employee’s signature (This form is not valid unless you sign it.)

Date

Employers Only

Employer’s name and address

First date of employment

Employer identification number (EIN)

---

For Privacy Act and Paperwork Reduction Act Notice, see page 3.

Cat. No. 10220Q

Form W-4 (2023)
General Instructions

Section references are to the Internal Revenue Code.

Future Developments

For the latest information about developments related to Form W-4, such as legislation enacted after it was published, go to www.irs.gov/FormW4.

Purpose of Form

Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay. If too little is withheld, you will generally owe tax when you file your tax return and may owe a penalty. If too much is withheld, you will generally be due a refund. Complete a new Form W-4 when changes to your personal or financial situation would change the entries on the form. For more information on withholding and when you must furnish a new Form W-4, see Pub. 505, Tax Withholding and Estimated Tax.

Exemption from withholding. You may claim exemption from withholding for 2023 if you meet both of the following conditions: you had no federal income tax liability in 2022 and you expect to have no federal income tax liability in 2023. You had no federal income tax liability in 2022 if (1) your total tax on line 24 on your 2022 Form 1040 or 1040-SR is zero (or less than the sum of lines 27, 28, and 29), or (2) you were not required to file a return because your income was below the filing threshold for your correct filing status. If you claim exemption, you will have no income tax withheld from your paycheck and may owe taxes and penalties when you file your 2023 tax return. To claim exemption from withholding, certify that you meet both of the conditions above by writing “Exempt” on Form W-4 in the space below Step 4(c). Then, complete Steps 1(a), 1(b), and 5. Do not complete any other steps. You will need to submit a new Form W-4 by February 15, 2024.

Your privacy. If you have concerns with Step 2(c), you may choose Step 2(b); if you have concerns with Step 4(a), you may enter an additional amount you want withheld per pay period in Step 4(c).

Self-employment. Generally, you will owe both income and self-employment taxes on any self-employment income you receive separate from the wages you receive as an employee. If you want to pay income and self-employment taxes through withholding from your wages, you should enter the self-employment income on Step 4(a). Then compute your self-employment tax, divide that tax by the number of pay periods remaining in the year, and include that resulting amount per pay period on Step 4(c). You can also add half of the annual amount of self-employment tax to Step 4(b) as a deduction. To calculate self-employment tax, you generally multiply the self-employment income by 14.13% (this rate is a quick way to figure your self-employment tax and equals the sum of the 12.4% social security tax and the 2.9% Medicare tax multiplied by 0.9235). See Pub. 505 for more information, especially if the sum of self-employment income multiplied by 0.9235 and wages exceeds $160,200 for a given individual.

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

Specific Instructions

Step 1(c). Check your anticipated filing status. This will determine the standard deduction and tax rates used to compute your withholding.

Step 2. Use this step if you (1) have more than one job at the same time, or (2) are married filing jointly and you and your spouse both work.

If you (and your spouse) have a total of only two jobs, you may check the box in option (c). The box must also be checked on the Form W-4 for the other job. If the box is checked, the standard deduction and tax brackets will be cut in half for each job to calculate withholding. This option is roughly accurate for jobs with similar pay; otherwise, more tax than necessary may be withheld, and this extra amount will be larger the greater the difference in pay is between the two jobs.

Multiple jobs. Complete Steps 3 through 4(b) on only one Form W-4. Withholding will be most accurate if you do this on the Form W-4 for the highest paying job.

Step 3. This step provides instructions for determining the amount of the child tax credit and the credit for other dependents that you may be able to claim when you file your tax return. To qualify for the child tax credit, the child must be under age 17 as of December 31, must be your dependent who generally lives with you for more than half the year, and must have the required social security number. You may be able to claim a credit for other dependents for whom a child tax credit can’t be claimed, such as an older child or a qualifying relative. For additional eligibility requirements for these credits, see Pub. 501, Dependents, Standard Deduction, and Filing Information. You can also include other tax credits for which you are eligible in this step, such as the foreign tax credit and the education tax credits. To do so, add an estimate of the amount for the year to your credits for dependents and enter the total amount in Step 3. Including these credits will increase your paycheck and reduce the amount of any refund you may receive when you file your tax return.

Step 4 (optional).

Step 4(a). Enter in this step the total of your other estimated income for the year, if any. You shouldn’t include income from any jobs or self-employment. If you complete Step 4(a), you likely won’t have to make estimated tax payments for that income. If you prefer to pay estimated tax rather than having tax on other income withheld from your paycheck, see Form 1040-ES, Estimated Tax for Individuals.

Step 4(b). Enter in this step the amount from the Deductions Worksheet, line 5, if you expect to claim deductions other than the basic standard deduction on your 2023 tax return and want to reduce your withholding to account for these deductions. This includes both itemized deductions and other deductions such as for student loan interest and IRAs.

Step 4(c). Enter in this step any additional tax you want withheld from your pay each pay period, including any amounts from the Multiple Jobs Worksheet, line 4. Entering an amount here will reduce your paycheck and will either increase your refund or reduce any amount of tax that you owe.
Step 2(b)—Multiple Jobs Worksheet (Keep for your records.)

If you choose the option in Step 2(b) on Form W-4, complete this worksheet (which calculates the total extra tax for all jobs) on only ONE Form W-4. Withholding will be most accurate if you complete the worksheet and enter the result on the Form W-4 for the highest paying job. To be accurate, submit a new Form W-4 for all other jobs if you have not updated your withholding since 2019.

Note: If more than one job has annual wages of more than $120,000 or there are more than three jobs, see Pub. 505 for additional tables.

1 Two jobs. If you have two jobs or you're married filing jointly and you and your spouse each have one job, find the amount from the appropriate table on page 4. Using the “Higher Paying Job” row and the “Lower Paying Job” column, find the value at the intersection of the two household salaries and enter that value on line 1. Then, skip to line 3.

   $1

2 Three jobs. If you and/or your spouse have three jobs at the same time, complete lines 2a, 2b, and 2c below. Otherwise, skip to line 3.
   a Find the amount from the appropriate table on page 4 using the annual wages from the highest paying job in the “Higher Paying Job” row and the annual wages for your next highest paying job in the “Lower Paying Job” column. Find the value at the intersection of the two household salaries and enter that value on line 2a.

   $2a

   b Add the annual wages of the two highest paying jobs from line 2a together and use the total as the wages in the “Higher Paying Job” row and use the annual wages for your third job in the “Lower Paying Job” column to find the amount from the appropriate table on page 4 and enter this amount on line 2b.

   $2b

   c Add the amounts from lines 2a and 2b and enter the result on line 2c.

   $2c

3 Enter the number of pay periods per year for the highest paying job. For example, if that job pays weekly, enter 52; if it pays every other week, enter 26; if it pays monthly, enter 12, etc.

   3

4 Divide the annual amount on line 1 or line 2c by the number of pay periods on line 3. Enter this amount here and in Step 4(c) of Form W-4 for the highest paying job (along with any other additional amount you want withheld).

   $4

Step 4(b)—Deductions Worksheet (Keep for your records.)

1 Enter an estimate of your 2023 itemized deductions (from Schedule A (Form 1040)). Such deductions may include qualifying home mortgage interest, charitable contributions, state and local taxes (up to $10,000), and medical expenses in excess of 7.5% of your income.

   $1

2 Enter:
   • $27,700 if you’re married filing jointly or a qualifying surviving spouse
   • $20,800 if you’re head of household
   • $13,850 if you’re single or married filing separately

   $2

3 If line 1 is greater than line 2, subtract line 2 from line 1 and enter the result here. If line 2 is greater than line 1, enter “-0-”.

   $3

4 Enter an estimate of your student loan interest, deductible IRA contributions, and certain other adjustments (from Part II of Schedule 1 (Form 1040)). See Pub. 505 for more information.

   $4

5 Add lines 3 and 4. Enter the result here and in Step 4(b) of Form W-4.

   $5

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(t)(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 with no other entries on the form; 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 territories 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.
### Married Filing Jointly or Qualifying Surviving Spouse

<table>
<thead>
<tr>
<th>Higher Paying Job Annual Taxable Wage &amp; Salary</th>
<th>Lower Paying Job Annual Taxable Wage &amp; Salary</th>
</tr>
</thead>
<tbody>
<tr>
<td>$0 - 9,999</td>
<td>$0 - 9,999</td>
</tr>
<tr>
<td>$10,000 - 19,999</td>
<td>$10,000 - 19,999</td>
</tr>
<tr>
<td>$20,000 - 29,999</td>
<td>$20,000 - 29,999</td>
</tr>
<tr>
<td>$30,000 - 39,999</td>
<td>$30,000 - 39,999</td>
</tr>
<tr>
<td>$40,000 - 49,999</td>
<td>$40,000 - 49,999</td>
</tr>
<tr>
<td>$50,000 - 59,999</td>
<td>$50,000 - 59,999</td>
</tr>
<tr>
<td>$60,000 - 69,999</td>
<td>$60,000 - 69,999</td>
</tr>
<tr>
<td>$70,000 - 79,999</td>
<td>$70,000 - 79,999</td>
</tr>
<tr>
<td>$80,000 - 89,999</td>
<td>$80,000 - 89,999</td>
</tr>
<tr>
<td>$90,000 - 99,999</td>
<td>$90,000 - 99,999</td>
</tr>
<tr>
<td>$100,000 - 109,999</td>
<td>$100,000 - 109,999</td>
</tr>
<tr>
<td>$110,000 - 120,000</td>
<td>$110,000 - 120,000</td>
</tr>
</tbody>
</table>

### Single or Married Filing Separately

<table>
<thead>
<tr>
<th>Higher Paying Job Annual Taxable Wage &amp; Salary</th>
<th>Lower Paying Job Annual Taxable Wage &amp; Salary</th>
</tr>
</thead>
<tbody>
<tr>
<td>$0 - 9,999</td>
<td>$0 - 9,999</td>
</tr>
<tr>
<td>$10,000 - 19,999</td>
<td>$10,000 - 19,999</td>
</tr>
<tr>
<td>$20,000 - 29,999</td>
<td>$20,000 - 29,999</td>
</tr>
<tr>
<td>$30,000 - 39,999</td>
<td>$30,000 - 39,999</td>
</tr>
<tr>
<td>$40,000 - 49,999</td>
<td>$40,000 - 49,999</td>
</tr>
<tr>
<td>$50,000 - 59,999</td>
<td>$50,000 - 59,999</td>
</tr>
<tr>
<td>$60,000 - 69,999</td>
<td>$60,000 - 69,999</td>
</tr>
<tr>
<td>$70,000 - 79,999</td>
<td>$70,000 - 79,999</td>
</tr>
<tr>
<td>$80,000 - 89,999</td>
<td>$80,000 - 89,999</td>
</tr>
<tr>
<td>$90,000 - 99,999</td>
<td>$90,000 - 99,999</td>
</tr>
<tr>
<td>$100,000 - 109,999</td>
<td>$100,000 - 109,999</td>
</tr>
<tr>
<td>$110,000 - 120,000</td>
<td>$110,000 - 120,000</td>
</tr>
</tbody>
</table>

### Head of Household

<table>
<thead>
<tr>
<th>Higher Paying Job Annual Taxable Wage &amp; Salary</th>
<th>Lower Paying Job Annual Taxable Wage &amp; Salary</th>
</tr>
</thead>
<tbody>
<tr>
<td>$0 - 9,999</td>
<td>$0 - 9,999</td>
</tr>
<tr>
<td>$10,000 - 19,999</td>
<td>$10,000 - 19,999</td>
</tr>
<tr>
<td>$20,000 - 29,999</td>
<td>$20,000 - 29,999</td>
</tr>
<tr>
<td>$30,000 - 39,999</td>
<td>$30,000 - 39,999</td>
</tr>
<tr>
<td>$40,000 - 49,999</td>
<td>$40,000 - 49,999</td>
</tr>
<tr>
<td>$50,000 - 59,999</td>
<td>$50,000 - 59,999</td>
</tr>
<tr>
<td>$60,000 - 69,999</td>
<td>$60,000 - 69,999</td>
</tr>
<tr>
<td>$70,000 - 79,999</td>
<td>$70,000 - 79,999</td>
</tr>
<tr>
<td>$80,000 - 89,999</td>
<td>$80,000 - 89,999</td>
</tr>
<tr>
<td>$90,000 - 99,999</td>
<td>$90,000 - 99,999</td>
</tr>
<tr>
<td>$100,000 - 109,999</td>
<td>$100,000 - 109,999</td>
</tr>
<tr>
<td>$110,000 - 120,000</td>
<td>$110,000 - 120,000</td>
</tr>
</tbody>
</table>
Employee's Withholding Allowance Certificate

Complete this form so that your employer can withhold the correct California state income tax from your paycheck.

### Enter Personal Information

<table>
<thead>
<tr>
<th>First, Middle, Last Name</th>
<th>Social Security Number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Address</th>
<th>Filing Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>City</td>
<td>Single or Married (with two or more incomes)</td>
</tr>
<tr>
<td>State ZIP Code</td>
<td>Married (one income)</td>
</tr>
<tr>
<td></td>
<td>Head of Household</td>
</tr>
</tbody>
</table>

1. Use Worksheet A for Regular Withholding allowances. Use other worksheets on the following pages as applicable.
   1a. Number of Regular Withholding Allowances (Worksheet A) 0
   1b. Number of allowances from the Estimated Deductions (Worksheet B, if applicable.) 0
   1c. Total Number of Allowances you are claiming 0

2. Additional amount, if any, you want withheld each pay period (if employer agrees), (Worksheet C)

### Exemption from Withholding

3. I claim exemption from withholding for 2023, and I certify I meet both of the conditions for exemption. (Check box here)

4. I certify under penalty of perjury that I am not subject to California withholding. I meet the conditions set forth under the Service Member Civil Relief Act, as amended by the Military Spouses Residency Relief Act and the Veterans Benefits and Transition Act of 2018. (Check box here)

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.

Employee's Signature ___________________________ Date ____________

### Employer's Section: Employer's Name and Address

- California Employer Payroll Tax Account Number

<table>
<thead>
<tr>
<th>Employer's Name and Address</th>
<th>California Employer Payroll Tax Account Number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Purpose: This certificate, DE 4, is for California Personal Income Tax (PIT) 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.

Beginning January 1, 2020, Employee’s Withholding Allowance Certificate (Form W-4) from the Internal Revenue Service (IRS) will be used for federal income tax withholding only. You must file the state form Employee’s Withholding Allowance Certificate (DE 4) to determine the appropriate California PIT withholding.

If you do not provide your employer with a withholding certificate, the employer must use Single with Zero withholding allowance.

### Check Your Withholding: After your 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.

### Exemption From Withholding: If you wish to claim exempt, complete the federal Form W-4 and the state DE 4. You may claim exempt from withholding California income tax if you meet both of the following conditions for exemption:

1. You did not owe any federal/state income tax last year, and
2. You do not expect to owe any federal/state income tax this year. The exemption is good for one year.

If you continue to qualify for the exempt filing status, a new DE 4 designating exempt must be submitted by February 15 each year to continue your exemption. If you are not having federal/state income tax withheld this year but expect to have a tax liability next year, you are required to give your employer a new DE 4 by December 1.

### Member Service Civil Relief Act: Under this act, as provided by the Military Spouses Residency Relief Act and the Veterans Benefits and Transition Act of 2018, you may be exempt from California income tax withholding 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 4.

You may be required to provide proof of exemption upon request.
The *California Employer’s Guide (DE 44)* (edd.ca.gov/pdf_pub_ctr/de44.pdf) provides the income tax withholding tables. This publication may be found by visiting *Payroll Taxes - Forms and Publications* (edd.ca.gov/Payroll_Taxes/Forms_and_Publications.htm). To assist you in calculating your tax liability, please visit the *Franchise Tax Board (FTB)* (ftb.ca.gov).

*If you need information on your last California Resident Income Tax Return (FTB Form 540), visit the FTB* (ftb.ca.gov).

---

**Notification**: The burden of proof rests with the employee to show the correct California income tax withholding. Pursuant to section 4340-1(e) of *Title 22, California Code of Regulations (CCR)* (govt.westlaw.com/calregs/Search/Index), the FTB or the EDD may, by special direction in writing, require an employer to submit a Form W-4 or DE 4 when such forms are necessary for the administration of the withholding tax programs.

**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 by section 13101 of the *California Unemployment Insurance Code* (leginfo.legislature.ca.gov/faces/codes.xhtml) and section 19176 of the *Revenue and Taxation Code* (leginfo.legislature.ca.gov/faces/codes.xhtml).
Worksheets

Instructions — 1 — Allowances*

When determining your withholding allowances, you must consider your personal situation:
— Do you claim allowances for dependents or blindness?
— Will you itemize your deductions?
— Do you have more than one income coming into the household?

Two-Earners/Multiple Incomes: When earnings are derived from more than one source, under-withholding may occur. If you have a working spouse or more than one job, it is best to check the box “SINGLE or MARRIED (with two or more incomes).” Figure the total number of allowances you are entitled to claim on all jobs using only one DE 4 form. Claim allowances with one employer.

Do not claim the same allowances with more than one employer. Your withholding will usually be most accurate when all allowances are claimed on the DE 4 filed for the highest paying job and zero allowances are claimed for the others.

Worksheet A

Regular Withholding Allowances

(A) Allowance for yourself — enter 1
(B) Allowance for your spouse (if not separately claimed by your spouse) — enter 1
(C) Allowance for blindness — yourself — enter 1
(D) Allowance for blindness — your spouse (if not separately claimed by your spouse) — enter 1
(E) Allowance(s) for dependent(s) — do not include yourself or your spouse
(F) Total — add lines (A) through (E) above and enter on line 1a of the DE 4

Instructions — 2 — (Optional) Additional Withholding Allowances

If you expect to itemize deductions on your California income tax return, you can claim additional withholding allowances. Use Worksheet B to determine whether your expected estimated deductions may entitle you to claim one or more additional withholding allowances. Use last year’s FTB Form 540 as a model to calculate this year’s withholding amounts.

Do not include deferred compensation, qualified pension payments, or flexible benefits, etc., that are deducted from your gross pay but are not taxed on this worksheet.

You may reduce the amount of tax withheld from your wages by claiming one additional withholding allowance for each $1,000, or fraction of $1,000, by which you expect your estimated deductions for the year to exceed your allowable standard deduction.

Worksheet B

Estimated Deductions

Use this worksheet only if you plan to itemize deductions, claim certain adjustments to income, or have a large amount of nonwage income not subject to withholding.

1. Enter an estimate of your itemized deductions for California taxes for this tax year as listed in the schedules in the FTB Form 540
2. Enter $10,404 if married filing joint with two or more allowances, unmarried head of household, or qualifying widow(er) with dependent(s) or $5,202 if single or married filing separately, dual income married, or married with multiple employers
3. Subtract line 2 from line 1, enter difference
4. Enter an estimate of your adjustments to income (alimony payments, IRA deposits)
5. Add line 4 to line 3, enter sum
6. Enter an estimate of your nonwage income (dividends, interest income, alimony receipts)
7. If line 5 is greater than line 6 (if less, see below [go to line 9]); Subtract line 6 from line 5, enter difference
8. Divide the amount on line 7 by $1,000, round any fraction to the nearest whole number enter this number on line 1b of the DE 4. Complete Worksheet C, if needed, otherwise stop here.
9. If line 6 is greater than line 5;
   Enter amount from line 6 (nonwage income)
10. Enter amount from line 5 (deductions)
11. Subtract line 10 from line 9, enter difference. Then, complete Worksheet C.

*Wages paid to registered domestic partners will be treated the same for state income tax purposes as wages paid to spouses for California PIT withholding and PIT wages. This law does not impact federal income tax law. A registered domestic partner means an individual partner in a domestic partner relationship within the meaning of section 297 of the Family Code. For more information, please call our Taxpayer Assistance Center at 1-888-745-3886.
Worksheet C

Additional Tax Withholding and Estimated Tax

1. Enter estimate of total wages for tax year 2023.

2. Enter estimate of nonwage income (line 6 of Worksheet B).

3. Add line 1 and line 2. Enter sum.

4. Enter itemized deductions or standard deduction (line 1 or 2 of Worksheet B, whichever is largest).

5. Enter adjustments to income (line 4 of Worksheet B).

6. Add line 4 and line 5. Enter sum.

7. Subtract line 6 from line 3. Enter difference.

8. Figure your tax liability for the amount on line 7 by using the 2023 tax rate schedules below.

9. Enter personal exemptions (line F of Worksheet A x $154.00).

10. Subtract line 9 from line 8. Enter difference.

11. Enter any tax credits. (See FTB Form 540).

12. Subtract line 11 from line 10. Enter difference. This is your total tax liability.

13. Calculate the tax withheld and estimated to be withheld during 2023. Contact your employer to request the amount that will be withheld on your wages based on the marital status and number of withholding allowances you will claim for 2023. Multiply the estimated amount to be withheld by the number of pay periods left in the year. Add the total to the amount already withheld for 2023.

14. Subtract line 13 from line 12. Enter difference. If this is less than zero, you do not need to have additional taxes withheld.

15. Divide line 14 by the number of pay periods remaining in the year. Enter this figure on line 2 of the DE 4.

Note: Your employer is not required to withhold the additional amount requested on line 2 of your DE 4. If your employer does not agree to withhold the additional amount, you may increase your withholdings as much as possible by using the “single” status with “zero” allowances. If the amount withheld still results in an underpayment of state income taxes, you may need to file quarterly estimates on Form 540-ES with the FTB to avoid a penalty.

These Tables Are for Calculating Worksheet C and for 2023 Only

<table>
<thead>
<tr>
<th>OVER</th>
<th>BUT NOT</th>
<th>OF AMOUNT OVER...</th>
<th>PLUS</th>
</tr>
</thead>
<tbody>
<tr>
<td>$0</td>
<td>$10,099</td>
<td>1.100%</td>
<td>$0</td>
</tr>
<tr>
<td>$10,099</td>
<td>$23,942</td>
<td>2.200%</td>
<td>$10,099</td>
</tr>
<tr>
<td>$23,942</td>
<td>$37,788</td>
<td>4.400%</td>
<td>$23,942</td>
</tr>
<tr>
<td>$37,788</td>
<td>$52,455</td>
<td>6.600%</td>
<td>$37,788</td>
</tr>
<tr>
<td>$52,455</td>
<td>$66,295</td>
<td>8.800%</td>
<td>$52,455</td>
</tr>
<tr>
<td>$66,295</td>
<td>$338,639</td>
<td>10.230%</td>
<td>$66,295</td>
</tr>
<tr>
<td>$338,639</td>
<td>$406,364</td>
<td>11.330%</td>
<td>$338,639</td>
</tr>
<tr>
<td>$406,364</td>
<td>$677,275</td>
<td>12.430%</td>
<td>$406,364</td>
</tr>
<tr>
<td>$677,275</td>
<td>$1,000,000</td>
<td>13.530%</td>
<td>$677,275</td>
</tr>
<tr>
<td>$1,000,000</td>
<td>and over</td>
<td>14.630%</td>
<td>$1,000,000</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>TAXABLE INCOME IS</th>
<th>COMPUTED TAX IS</th>
</tr>
</thead>
<tbody>
<tr>
<td>OVER</td>
<td>BUT NOT</td>
</tr>
<tr>
<td>$0</td>
<td>$20,198</td>
</tr>
<tr>
<td>$20,198</td>
<td>$47,884</td>
</tr>
<tr>
<td>$47,884</td>
<td>$75,576</td>
</tr>
<tr>
<td>$75,576</td>
<td>$104,910</td>
</tr>
<tr>
<td>$104,910</td>
<td>$132,590</td>
</tr>
<tr>
<td>$132,590</td>
<td>$677,275</td>
</tr>
<tr>
<td>$677,275</td>
<td>$812,728</td>
</tr>
<tr>
<td>$812,728</td>
<td>$1,000,000</td>
</tr>
<tr>
<td>$1,000,000</td>
<td>$1,354,550</td>
</tr>
<tr>
<td>$1,354,550</td>
<td>and over</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>TAXABLE INCOME IS</th>
<th>COMPUTED TAX IS</th>
</tr>
</thead>
<tbody>
<tr>
<td>OVER</td>
<td>BUT NOT</td>
</tr>
<tr>
<td>$0</td>
<td>$10,099</td>
</tr>
<tr>
<td>$10,099</td>
<td>$23,942</td>
</tr>
<tr>
<td>$23,942</td>
<td>$37,788</td>
</tr>
<tr>
<td>$37,788</td>
<td>$52,455</td>
</tr>
<tr>
<td>$52,455</td>
<td>$66,295</td>
</tr>
<tr>
<td>$66,295</td>
<td>$338,639</td>
</tr>
<tr>
<td>$338,639</td>
<td>$406,364</td>
</tr>
<tr>
<td>$406,364</td>
<td>$677,275</td>
</tr>
<tr>
<td>$677,275</td>
<td>$1,000,000</td>
</tr>
<tr>
<td>$1,000,000</td>
<td>and over</td>
</tr>
</tbody>
</table>

If you need information on your last California Resident Income Tax Return, FTB Form 540, visit FTB (ftb.ca.gov).

The DE 4 information is collected for purposes of administering the PIT law and under the authority of Title 22, CCR, section 4340-1, and the California Revenue and Taxation Code, including section 18624. The Information Practices Act of 1977 requires that individuals be notified of how information they provide may be used. Further information is contained in the instructions that came with your last California resident income tax return.
Statement Concerning Your Employment in a Job Not Covered by Social Security

Employee Name ___________________________ Employee ID# ___________________________

Employer Name ___________________________ Employer ID# ___________________________

Your earnings from this job are not covered under Social Security. When you retire, or if you become disabled, you may receive a pension based on earnings from this job. If you do, and you are also entitled to a benefit from Social Security based on either your own work or the work of your husband or wife, or former husband or wife, your pension may affect the amount of the Social Security benefit you receive. Your Medicare benefits, however, will not be affected. Under the Social Security law, there are two ways your Social Security benefit amount may be affected.

Windfall Elimination Provision
Under the Windfall Elimination Provision, your Social Security retirement or disability benefit is figured using a modified formula when you are also entitled to a pension from a job where you did not pay Social Security tax. As a result, you will receive a lower Social Security benefit than if you were not entitled to a pension from this job. For example, if you are age 62 in 2013, the maximum monthly reduction in your Social Security benefit as a result of this provision is $395.50. This amount is updated annually. This provision reduces, but does not totally eliminate, your Social Security benefit. For additional information, please refer to Social Security Publication, “Windfall Elimination Provision.”

Government Pension Offset Provision
Under the Government Pension Offset Provision, any Social Security spouse or widow(er) benefit to which you become entitled will be offset if you also receive a Federal, State or local government pension based on work where you did not pay Social Security tax. The offset reduces the amount of your Social Security spouse or widow(er) benefit by two-thirds of the amount of your pension.

For example, if you get a monthly pension of $600 based on earnings that are not covered under Social Security, two-thirds of that amount, $400, is used to offset your Social Security spouse or widow(er) benefit. If you are eligible for a $500 widow(er) benefit, you will receive $100 per month from Social Security ($500 - $400=$100). Even if your pension is high enough to totally offset your spouse or widow(er) Social Security benefit, you are still eligible for Medicare at age 65. For additional information, please refer to Social Security Publication, “Government Pension Offset.”

For More Information
Social Security publications and additional information, including information about exceptions to each provision, are available at www.socialsecurity.gov. You may also call toll free 1-800-772-1213, or for the deaf or hard of hearing call the TTY number 1-800-325-0778, or contact your local Social Security office.

I certify that I have received Form SSA-1945 that contains information about the possible effects of the Windfall Elimination Provision and the Government Pension Offset Provision on my potential future Social Security Benefits.

Signature of Employee ___________________________ Date ___________________________
Information about Social Security Form SSA-1945 Statement Concerning Your Employment in a Job Not Covered by Social Security

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

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

Employers must:

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

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

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

In the event a salary overpayment made to me in error, I authorize the Fowler Unified School District to recover the overpayment through a payroll deduction at the time the overpayment is discovered.

I further understand that should I terminate employment before the overpayment has been collected, the balance is due and payable at the time of resignation.

This authorization form is in affect for the duration of my employment with Fowler Unified School District.

Employee Signature: ____________________________________________

Employee Name (Print): ________________________________________

Date: _________________________________________________________
Fowler Unified School District

ADULT TUBERCULOSIS (TB) RISK ASSESSMENT
(To satisfy California Education Code Section 49406 and Health Code Sections 121525-121555)

<table>
<thead>
<tr>
<th>Employee Name</th>
<th>Employee Last 4 SSN</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Site/Department  Position Title

I hereby give consent to administer the Adult Tuberculosis (TB) Risk Assessment. Furthermore, I certify that my answers below are true and correct.

<table>
<thead>
<tr>
<th>Employee Signature</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>History of positive TB test or TB disease</th>
<th>Yes ☐ No ☐</th>
</tr>
</thead>
</table>

New Employee: If yes, a symptom review and chest x-ray should be performed at initial hire (if none performed in previous 6 months).
Existing Employee: Continue with questions below:

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

☐ All answers are NO. The above named employee has submitted to a Tuberculosis Risk Assessment and does not have risk factors and therefore does not need to receive the PPD at this time.

☐ Some answers are YES. If there is a “Yes” response to any of the questions 1-5 above, then a Tuberculin Skin Test (TST) or Interferon Gamma Release Assay (IGRA) may be performed.
A positive test should be followed by a chest x-ray, and if normal, treatment for TB infection considered.

☐ Employee elects Fowler USD to administer Tuberculin Skin Test (TST).
☐ Employee elects outside medical examination.

<table>
<thead>
<tr>
<th>/RN</th>
<th>Print Name of Administering Personnel</th>
<th>Date of Risk Assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fowler Unified School District</td>
<td>Fowler CA 93625</td>
<td>559 834-6083</td>
</tr>
</tbody>
</table>

Original: Human Resources

5/1/2015
Certificate of Medical Examination of Applicants
(for First Employment in California School District or County Superintendent of Schools Office)

NAME: ___________________________ Last 4 SSN _______ DATE OF BIRTH: ____________

ADDRESS: ___________________________ STREET ___________ CITY ___________ STATE ___________ ZIP CODE ___________

To the Physician:

The medical examination required of a person employed in a certificated position for the first time in a California School District or County Superintendent of Schools Office to determine freedom from any disabling disease unfitting the person to instruct or associate with children should be evaluated on the basis of the functions which will be required of the applicant upon employment.

Disabling disease should be considered in terms of: (1) Evidence of lack of ability to demonstrate average physical and emotional capacity for the functions involved; (2) Evidence of disability, which periodically may disable the individual; for example, rheumatoid arthritis, uncontrolled diabetes, asthma; and (3) Evidence of long term disability, which may progressively deteriorate; for example, malignancy, Multiple Sclerosis.

<table>
<thead>
<tr>
<th>CHECK EVERY ITEM</th>
<th>YES</th>
<th>NO</th>
<th>DETAILS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is there evidence of disabling disease of the musculo-skeletal, cardio-vascular, nervous, gastro-intestinal, genito-urinary, endocrine systems?</td>
<td>YES</td>
<td>NO</td>
<td>DETAILS</td>
</tr>
<tr>
<td>Is there evidence of disabling metabolic disease?</td>
<td>YES</td>
<td>NO</td>
<td>DETAILS</td>
</tr>
<tr>
<td>Is there evidence of infectious disease in a communicable stage?</td>
<td>YES</td>
<td>NO</td>
<td>DETAILS</td>
</tr>
<tr>
<td>Is there evidence of drug dependency including alcoholism?</td>
<td>YES</td>
<td>NO</td>
<td>DETAILS</td>
</tr>
<tr>
<td>Is there evidence of any other disabling disease?</td>
<td>YES</td>
<td>NO</td>
<td>DETAILS</td>
</tr>
</tbody>
</table>

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

NAME OF PHYSICIAN (PLEASE PRINT) ___________________________ LICENSE # _______

SIGNATURE OF PHYSICIAN ___________________________________ DATE ___________

Revised: 09/2021
NOTICE OF EXCLUSION FROM CalPERS MEMBERSHIP

1. SOCIAL SECURITY NUMBER
Your employer has contracted with the California Public Employees’ Retirement System (CalPERS) to provide an employee benefit package which includes service retirement, death, and disability benefits.

2. CURRENT NAME (LAST) (FIRST) (MIDDLE)

3. NAME OF PUBLIC AGENCY
Fowler Unified School District

4. DEPARTMENT OR SCHOOL DISTRICT
School District

5. JOB OR POSITION TITLE

6. TERM OF APPOINTMENT
Permanently

7. IF TEMPORARY, ENTER NEAREST NUMBER OF WHOLE MONTHS THE APPOINTMENT IS EXPECTED TO LAST.

8. APPOINTMENT DATE
MM DD YYYY

9. TIME BASE

   [ ] FULL-TIME
   [ ] PART-TIME
   [ ] INDETERMINATE
   [ ] PART-TIME IF PART TIME, ENTER THE FRACTION OF FULL TIME:

In your present position with this agency, you are excluded from CalPERS membership because:

   [ ] 1. Your full-time seasonal or limited term appointment is limited to 6 months or less.

   [ ] 2. Your part-time appointment is limited to less than an average of 20 hours per week for less than one year.

   [ ] 3. Your appointment is an on-call, intermittent, emergency, substitute, or other irregular basis which excludes you from membership until you have worked 1,000 hours (or 125 days if paid on per diem basis) this fiscal year.

   [ ] 4. Your position is excluded by law or by contract agreement which excludes:

   ____________________________________________________________ Enter contract exclusion (for Public Agencies only).

   [ ] 5. You are an independent contractor.

   [ ] 6. You are employed to render professional legal service to a city.

   Exceptions: Persons holding the office of city attorney, deputy city attorney, or assistant city attorney.

   [ ] 7. You are employed as a student aide by a school district in a position established for students only and you are attending school in the same district (for County Schools only).

   NOTE: If you are a member of CalPERS by previous employment (either you have funds on deposit or service credit), exclusions 1, 2, and 3 do not apply to you and you should be a member in your present position. Be sure to notify your employer to complete a (PERS-1) Member Action Request Form or appoint via ACES to report your employment to CalPERS.

If you believe that your employment does qualify you for CalPERS membership, ask your employer for an explanation. You can also contact CalPERS directly by sending a letter stating the reasons why you feel you should be a member to the Employer Account Management Division, Membership Management Section, P.O. Box 942709, Sacramento, CA 94229-2709.

SIGNATURE OF CERTIFYING OFFICER

SIGNATURE OF EMPLOYEE

NOTE: Benefits provided by CalPERS are described in the “CalPERS Benefits” information booklet available from your employer.

PERS-EAMD-139 (3/17)

California Public Employees’ Retirement System
www.calpers.ca.gov
Dear Member,

The California Public Employees’ Retirement System (CalPERS) requires all members hired after January 1, 2013 complete the Reciprocal Self-Certification Form (PERS-EAMD-801) to provide essential information that will be used by your employer to enroll you in CalPERS membership.

This form obtains information regarding your membership in other qualifying public retirement systems and must be returned to your employer within 10 business days of receipt. Use the instructions provided on the back of the form and reference the List of Qualifying Public Retirement Systems for assistance. Information regarding your membership in a defined benefit plan for any of the listed qualifying public retirement system must be provided. However, information related to CalPERS membership should not be included when completing this form, as this data is already stored in the CalPERS system.

It is your responsibility to ensure the accuracy and completeness of the information you provide. Inaccurate information may result in adjustments to your account which could lead to adverse impacts such as incurring financial obligations that you and your employer will be responsible to fulfill.

For more information regarding the Reciprocal Self-Certification Form, please visit our website at www.calpers.ca.gov.

Please note: The completion of the Reciprocal Self-Certification Form does not establish reciprocity, nor is it a request to establish reciprocity. To request that reciprocity be established, download the When You Change Retirement Systems (PUB 16) publication to obtain the Confirmation of Intent to Establish Reciprocity When Changing Retirement Systems (PERS-CASD-255) form. This publication is available at www.calpers.ca.gov.

Sincerely,

Membership Services

Enclosures: List of Qualifying Public Retirement Systems in California, Reciprocal Self-Certification Form, and Directions for Completing Reciprocal Self-Certification Form
## List of Qualifying Public Retirement Systems in California

<table>
<thead>
<tr>
<th>Name of Public Retirement System</th>
<th>Qualifications:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alameda County Employees’ Retirement Association^</td>
<td></td>
</tr>
<tr>
<td>City and County of San Francisco Employees’ Retirement System*</td>
<td></td>
</tr>
<tr>
<td>City of Concord Retirement System*</td>
<td></td>
</tr>
<tr>
<td>City of Costa Mesa Public Retirement System*</td>
<td></td>
</tr>
<tr>
<td>City of Fresno Retirement System</td>
<td></td>
</tr>
<tr>
<td>City of Pasadena Fire and Police Retirement System</td>
<td>Safety only</td>
</tr>
<tr>
<td>City of San Clemente*</td>
<td>Fire and police only</td>
</tr>
<tr>
<td>Contra Costa County Employees’ Retirement Association^</td>
<td>Non-safety (miscellaneous) only</td>
</tr>
<tr>
<td>Contra Costa Water District</td>
<td></td>
</tr>
<tr>
<td>East Bay Municipal Utility District</td>
<td></td>
</tr>
<tr>
<td>East Bay Regional Park District</td>
<td>Safety only</td>
</tr>
<tr>
<td>Fresno County Employees’ Retirement Association^</td>
<td></td>
</tr>
<tr>
<td>Imperial County Employees’ Retirement Association^</td>
<td></td>
</tr>
<tr>
<td>Judges Retirement System II</td>
<td></td>
</tr>
<tr>
<td>Kern County Employees’ Retirement System^</td>
<td></td>
</tr>
<tr>
<td>Legislators’ Retirement System</td>
<td></td>
</tr>
<tr>
<td>Los Angeles City Employees’ Retirement System</td>
<td>Non-safety (miscellaneous) only; L.A. Fire and Police Pension System and L.A. Water and Power Employees’ Retirement System not eligible</td>
</tr>
<tr>
<td>Los Angeles County Employees’ Retirement Association^</td>
<td></td>
</tr>
<tr>
<td>Los Angeles County Metropolitan Transportation Authority</td>
<td>Non-contract Employees’ Retirement Income Plan, formerly Southern California Rapid Transit District</td>
</tr>
<tr>
<td>Marin County Employees’ Retirement Association^</td>
<td></td>
</tr>
<tr>
<td>Mendocino County Employees’ Retirement Association^</td>
<td></td>
</tr>
<tr>
<td>Merced County Employees’ Retirement Association^</td>
<td></td>
</tr>
<tr>
<td>Oakland Municipal Employees’ Retirement System (City of Oakland)</td>
<td>Non-safety (miscellaneous) only</td>
</tr>
<tr>
<td>Orange County Employees’ Retirement System^</td>
<td></td>
</tr>
<tr>
<td>Sacramento City Employees’ Retirement System*</td>
<td></td>
</tr>
<tr>
<td>Sacramento County Employees’ Retirement System^</td>
<td>Defined benefit plan only; cash balance plans not eligible</td>
</tr>
<tr>
<td>San Bernardino County Retirement Association</td>
<td></td>
</tr>
<tr>
<td>San Diego County Retirement System</td>
<td>Defined benefit plan only; cash balance plans not eligible</td>
</tr>
<tr>
<td>San Diego County Employees’ Retirement Association^</td>
<td></td>
</tr>
<tr>
<td>San Joaquin County Employees’ Retirement Association^</td>
<td></td>
</tr>
<tr>
<td>San Jose Federated City Employees’ Retirement System</td>
<td></td>
</tr>
<tr>
<td>San Luis Obispo County Pension Trust</td>
<td></td>
</tr>
<tr>
<td>San Mateo County Employees’ Retirement Association^</td>
<td></td>
</tr>
<tr>
<td>Santa Barbara County Employees’ Retirement System^</td>
<td></td>
</tr>
<tr>
<td>Sonoma County Employees’ Retirement Association^</td>
<td></td>
</tr>
<tr>
<td>Stanislaus County Employees’ Retirement Association^</td>
<td></td>
</tr>
<tr>
<td>State Teachers’ Retirement System</td>
<td>Defined benefit plan only; cash balance plans not eligible</td>
</tr>
<tr>
<td>Tulare County Employees’ Retirement Association^</td>
<td></td>
</tr>
<tr>
<td>University of California Retirement Program</td>
<td>Defined benefit plan only; cash balance plans not eligible</td>
</tr>
<tr>
<td>Ventura County Employees’ Retirement Association^</td>
<td></td>
</tr>
</tbody>
</table>

^Also CalPERS-covered agency
^= 1937 Act Counties
Reciprocal Self-Certification Form

Complete the following information and return this form to your personnel office within 10 business days. To ensure this form is completed correctly, please reference the enclosed List of Qualifying Public Retirement Systems and instructions.

**Section 1. Member Information**

<table>
<thead>
<tr>
<th>Member Name:</th>
<th>(Last)</th>
<th>(First)</th>
<th>(Middle)</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Date of Birth:</th>
<th>CalPERS ID:</th>
</tr>
</thead>
</table>

Membership Status in Qualifying Public Retirement Systems:

- [ ] I have not been a member of a qualifying public retirement system in California. (skip to section 3)
- [ ] I have membership in a defined benefit plan under a qualifying public retirement system in California other than CalPERS. (complete section 2 with membership information for each qualifying public retirement system)

**Section 2. Qualifying Reciprocal Membership Information**

<table>
<thead>
<tr>
<th>Name of Most Recent Public Retirement System:</th>
<th>Membership Date:</th>
<th>Separation Date*:</th>
<th>[ ] Retired* or [ ] Refunded*</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>/ /</td>
<td>/ /</td>
<td>Date: / /</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Name of Prior Public Retirement System:</th>
<th>Membership Date:</th>
<th>Separation Date*:</th>
<th>[ ] Retired* or [ ] Refunded*</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>/ /</td>
<td>/ /</td>
<td>Date: / /</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Name of Prior Public Retirement System:</th>
<th>Membership Date:</th>
<th>Separation Date*:</th>
<th>[ ] Retired* or [ ] Refunded*</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>/ /</td>
<td>/ /</td>
<td>Date: / /</td>
</tr>
</tbody>
</table>

*Please provide dates, if applicable. Not all sections may be applicable for each Public Retirement System.

**Section 3. Sign and Certify**

I understand that by accepting employment in a qualified public retirement system, I am subject to the applicable laws and regulations of that system. I also understand that completing this form is not a request to establish reciprocity.

I hereby certify that the foregoing information has been verified with the qualifying public retirement system as true and correct and any information found to be incorrect may require corrections to my CalPERS account including, but not limited to, my retirement enrollment level and adjustments to my member contributions. CalPERS may make any necessary corrections to my account to ensure I am properly enrolled and eligible to receive the correct retirement benefits.

**Member Signature:**

**Date:**

**Section 4. To Be Completed by Employer Only**

Name of CalPERS Agency:

CalPERS Business Partner ID:  
Member’s Enrollment Eligibility Date:

Designee of Employer: (print name)  
Designees’ Title:

**Designee Signature:**

**Date:**

The employer must retain this form in the member’s file for auditing purposes.

For more direction regarding how to process the Reciprocal Self-Certification Form, please refer to our employer reference guides.
### Instructions for Completing the Reciprocal Self-Certification Form

#### Section 1. Member Information
- Complete the required fields with your name, date of birth, and CalPERS ID.
- Check one of the appropriate boxes to indicate if you have had membership in a defined benefit plan in one of the qualifying public retirement systems named on the enclosed list:
  - If you have not been a member of any of the qualifying public retirement systems, mark the first box and skip to section 3.
  - If you have membership in a defined benefit plan of any of the qualifying public retirement systems on the enclosed list, mark the second box and continue to section 2.
- This form is to obtain information regarding your membership in other qualifying public retirement systems; do not include CalPERS membership on this form.

#### Section 2. Qualifying Reciprocal Membership Information
- In the first column, titled “Name of Public Retirement System,” list the name of any qualifying public retirement systems you are a member of a defined benefit plan.
  - If you are a member of multiple qualifying public retirement systems, please provide the name of each system beginning with the most recent in descending order.
  - Please reference the enclosed List of Qualifying Public Retirement Systems in California. Only systems named on this list should be provided on the Reciprocal Self-Certification Form.
- In the second column, titled “Membership Date,” list your membership date in the qualifying public retirement system.
  - You must provide a full date, including month, date, and year, which corresponds to each qualifying public retirement system listed.
  - If you are unsure of your membership date, please contact the qualifying public retirement system to confirm information prior to completing the form.
- In the third column, titled “Separation Date,” list your separation date from the qualifying public retirement system.
  - This section may not be applicable for all qualifying public retirement systems. If you have not separated from the qualifying public retirement system, leave this field blank.
  - If you have separated from the qualifying public retirement system, you must provide a full date including month, date, and year.
  - If you are unsure of your separation date, please contact the qualifying public retirement system to confirm information prior to completing the form.
- In the fourth column, titled “Retired or Refunded,” indicate if you have retired or refunded from the qualifying public retirement system.
  - This section may not be applicable for all qualifying public retirement systems. If you have not retired or refunded from the qualifying public retirement system, leave this field blank.
  - If you have retired or refunded from the qualifying public retirement system, mark the appropriate box and provide a full date including month, date, and year.
  - Retired: You have separated from the qualifying public retirement system and receive a monthly retirement allowance.
  - Refunded: You have terminated your membership in the qualifying public retirement system by withdrawing your contributions.

#### Section 3. Sign and Certify
- Please read the statement. Then, sign your name and date the document before returning it to your personnel office.
Privacy Notice

The privacy of personal information is of the utmost importance to CalPERS. The following information is provided to you in compliance with the Information Practices Act of 1977 and the Federal Privacy Act of 1974.

**Information Purpose**

The information requested is collected pursuant to the Government Code (sections 20000 et seq.) and will be used for administration of Board duties under the Retirement Law, the Social Security Act, and the Public Employees’ Medical and Hospital Care Act, as the case may be. Submission of the requested information is mandatory. Failure to comply may result in CalPERS being unable to perform its functions regarding your status.

Please do not include information that is not requested.

**Social Security Numbers**

Social Security numbers are collected on a mandatory and voluntary basis. If this is CalPERS’ first request for disclosure of your Social Security number, then disclosure is mandatory. If your Social Security number has already been provided, disclosure is voluntary. Due to the use of Social Security numbers by other agencies for identification purposes, we may be unable to verify eligibility for benefits without the number.

Social Security numbers are used for the following purposes:
1. Enrollee identification
2. Payroll deduction/state contributions
3. Billing of contracting agencies for employee/employer contributions
4. Reports to CalPERS and other state agencies
5. Coordination of benefits among carriers
6. Resolving member appeals, complaints, or grievances with health plan carriers

**Information Disclosure**

 Portions of this information may be transferred to other state agencies (such as your employer), physicians, and insurance carriers, but only in strict accordance with current statutes regarding confidentiality.

**Your Rights**

You have the right to review your membership files maintained by the System. For questions about this notice, our Privacy Policy, or your rights, please write to the CalPERS Privacy Officer at 400 Q Street, Sacramento, CA 95811 or call us at 888 CalPERS (or 888-225-7377).
The following instructions are to assist you and your employer in completing the Retirement System Election form (ES 0372). Please read the instructions and information for retirement system coverage before completing the form. Please type or print legibly in dark ink.

INFORMATION

A member of the CalSTRS Defined Benefit Program who becomes employed by a school district, a community college district, a county superintendent of schools, limited state departments, or the California Community Colleges Board of Governors to perform service that requires membership in a different public retirement system, may elect to receive credit under the CalSTRS Defined Benefit Program for such service by completing a Retirement System Election form (ES 0372) within 60 days after the hire date requiring membership in the other system, and CalSTRS must receive the completed form within 60 days of the signature date. If the CalSTRS member does not elect to continue as a member of CalSTRS, all service subject to coverage by the other public retirement system will be reported to that retirement system. (Education Code sections 22508, 22508.5 and 22509)

A member of CalPERS who was employed by a school employer, Board of Governors of the California Community Colleges, or State Department of Education within 120 days before the member’s date of hire, or who has at least five years of CalPERS credited service, and who accepts employment to perform creditable service that requires membership by the CalSTRS Defined Benefit Program, may elect to receive credit under CalPERS for such service by submitting a Retirement System Election form (ES 0372) to CalPERS, within 60 days after the hire date of employment requiring membership in CalSTRS. If the CalPERS member does not elect to continue as a member of CalPERS, all CalSTRS creditable service will be reported to CalSTRS. (Government Code section 20309).

Education Code section 22509 requires that within 10 working days of hire, an employer must provide all employees who have the right to make this election with the information regarding their election rights and must make available written information about the retirement systems to assist the employee in making an election.

SECTION 1: MEMBER INFORMATION AND ELECTION

Section 1 must be completed by the employee with assistance from the employer. Please complete all entries in Section 1.

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

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

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

EMPLOYEE SIGNATURE – Sign and date the form. By signing this document, you certify that you have received information from your employer regarding your right to the Retirement System Election. You also certify that you understand this election is irrevocable, and that it is a crime to fail to disclose a material fact or to make any knowingly false material statements for the purpose of altering a benefit administered by CalSTRS which may result in up to one year in jail and a fine of up to $5,000. (Education Code section 22010)

Submit the signed and dated Retirement System Election form (ES 0372) to your employer. Retain a copy for your records.

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

SECTION 2: EMPLOYER CERTIFICATION

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

EMPLOYER:

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

POSITION EFFECTIVE DATE – Enter the first date that service was/will be performed by the employee in the new position.

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

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

EMPLOYER CERTIFICATION – Print school or state official’s name, title and phone number, and sign and date the form.

Submit the completed form to the County Office of Education.

If you represent a state department, submit the form directly to CalSTRS and retain a copy of the employee’s signed election form.

COUNTY OFFICE OF EDUCATION:
Print the County official’s name, title and phone number, and sign and date the form.

Retain a copy for your and the employee’s files.

SUBMIT
The Retirement System Election form (ES 0372) must be submitted to the retirement system elected by the employee. For additional requirements, please see the Information section.

Secure Employer Website: Send the completed form to the ES Forms Queue found in the Business Areas dropdown of the Recipient via SEW.

Email to: Submit this form via email to the esforms@calstrs.com mailbox unless otherwise instructed by your CalSTRS representative. If sending forms to the esforms@calstrs.com mailbox, please remove all Social Security numbers and only provide the Client ID where applicable.

Mail to: CalSTRS P.O. Box 15275, MS 17 Sacramento, CA 95851-0275
Please read the attached information and instructions before completing this form. Please type or print legibly in dark ink.

SECTION 1: Member Information and Election (to be completed by employee)

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

A member of CalSTRS who becomes employed in a new position by the same or a different school district, a community college district, a county superintendent of schools, limited state employment or the Board of Governors of the California Community Colleges, as defined in Education Code sections 22508 and 22508.5, to perform service that requires membership in a different public retirement system will have that service credited with that other public retirement system unless the member files a written election (within 60 days after the date of hire) to have that service covered by CalSTRS, pursuant to Education Code section 22508(a) or 22508.5(a).

I am a member of CalSTRS who has accepted employment to perform service that requires membership in a different public retirement system and am eligible to elect to continue retirement system coverage under CalSTRS.

I elect coverage in: (please choose one)

☐ CA State Teachers’ Retirement System (CalSTRS)
☐ CA Public Employee’s Retirement System (CalPERS) *
☐ A Different Public Retirement System identified here: ____________________________________________________________

OR

A member of CalPERS who was employed by a school employer, Board of Governors of the California Community Colleges or State Department of Education within 120 days before the member’s date of hire, or who has at least five years of CalPERS credited service, as defined in Government Code section 20309, and who is subsequently employed to perform creditable service that requires membership in the Defined Benefit Program of CalSTRS, will have that service credited with CalSTRS unless the member files a written election (within 60 days after the date of hire) to have the service credited with CalPERS, pursuant to Government Code section 20309.

I am a member of CalPERS who has accepted employment to perform service that requires membership in the CalSTRS Defined Benefit Program and am eligible to elect to continue coverage under CalPERS.

I elect coverage in: (please choose one)

☐ CA State Teachers’ Retirement System (CalSTRS)
☐ CA Public Employee’s Retirement System (CalPERS) *
With my signature below, I certify that I have received information from my employer regarding my eligibility to elect membership for this position as described on this form. I fully understand that this election is irrevocable. I understand it is a crime to fail to disclose a material fact or to make any knowingly false material statements for the purpose of altering or receiving a benefit administered by CalSTRS and it may result in up to one year in jail and/or a fine of up to $5,000 pursuant to Education Code section 22010.

EMPLOYEE SIGNATURE

SECTION 2: Employer Certification (to be completed by employer and County Office of Education)

With my signature below, I certify that I have provided information to the above employee regarding his/her eligibility to elect membership for this position, pursuant to Education Code section 22509. I certify the employee meets the qualifications to make a retirement system election, pursuant to Education Code sections 22508 or 22508.5, or Government Code section 20309.

<table>
<thead>
<tr>
<th>EMPLOYEE POSITION INFORMATION:</th>
</tr>
</thead>
<tbody>
<tr>
<td>POSITION HIRE DATE</td>
</tr>
<tr>
<td>SELECT ONE:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>EMPLOYER INFORMATION:</th>
</tr>
</thead>
<tbody>
<tr>
<td>CO/DIST/STATE DEPT NAME</td>
</tr>
<tr>
<td>SCHOOL/STATE OFFICIAL’S NAME</td>
</tr>
<tr>
<td>SIGNATURE OF SCHOOL/STATE OFFICIAL</td>
</tr>
<tr>
<td>COUNTY OFFICIAL’S NAME</td>
</tr>
<tr>
<td>SIGNATURE OF COUNTY OFFICIAL</td>
</tr>
</tbody>
</table>
If you are employed to perform creditable service in a position that is excluded from mandatory membership in the CalSTRS’ Defined Benefit (DB) Program, you may use this form to elect DB Program membership at any time while employed to perform creditable service.

A permissive election of membership in the DB Program applies to all future creditable service performed for the same or another employer, including any non-member or CalSTRS Cash Balance Benefit (CB) Program service you are currently performing. You may be entitled to elect coverage by the CB Program or California Public Employees’ Retirement System (CalPERS) for future eligible service as allowed by law. Please work with your employer if you believe you are entitled to make one of these elections.

A permissive election of membership in the DB Program is irrevocable. Membership may only be cancelled if you terminate all employment to perform creditable service and refund your accumulated retirement contributions from the CalSTRS DB Program.

SECTION 1: EMPLOYEE INFORMATION
(TO BE COMPLETED BY EMPLOYEE)

Provide the following information:
- CalSTRS Client ID* or Social Security Number
- Last Name, First Name and Middle Initial
- Mailing Address**, City, State and Zip Code
- Date of Birth
- Email Address
- Telephone Number

*If you have already been employed to perform creditable service you will have a CalSTRS Client ID, even if you were not formerly a member. Please provide your CalSTRS Client ID, if you have one, in lieu of your Social Security Number.

**To establish residency for tax purposes, we ask that you provide a street address. Be sure to include any street, apartment or suite number. If your post office does not deliver mail to your street address, you may enter your box number instead. If you reside outside the United States, use the CITY – STATE – ZIP field to provide your foreign address. If you receive your mail in care of a third party, enter “c/o” followed by the third party’s name and address.

SECTION 2: EMPLOYEE ELECTION
(TO BE COMPLETED BY EMPLOYEE)

If you want to elect membership in the CalSTRS DB Program:
- Check the appropriate box
- Provide your requested membership date***

***You will begin contributing to the DB Program as of your membership date. Your membership date can be no earlier than the first day of the pay period in which your election is made, or your first day of employment, whichever is later. Work with your employer to select the most beneficial, valid membership date you are eligible for. Electing an invalid membership date will require a revision to your election form and may result in delayed contributions to CalSTRS.

If you do not want to elect membership in the CalSTRS DB Program at this time, check the appropriate box.

SECTION 3: REQUIRED SIGNATURE
(TO BE COMPLETED BY EMPLOYEE)

Sign the form and date your signature.
Return the form to your employer.

SECTION 4: EMPLOYEE POSITION INFORMATION
(TO BE COMPLETED BY EMPLOYER)

Provide the position hire date – the date in which the employee was hired to perform creditable service in the position they are making this election for. CalSTRS defers to the employer as to the date in which you consider an employee to be hired. Provide the position title – the title of the position the employee is performing creditable service in.

SECTION 5: EMPLOYER INFORMATION AND CERTIFICATION
(TO BE COMPLETED BY EMPLOYER)

Verify the employee is eligible for the requested membership date.

Provide the following information:
- The employer (county or district) name
- County and district code
- Name and title of employer official completing the form

Sign the form and date your signature.
Submit the form to CalSTRS and retain a copy.
SUBMIT
This form should be submitted to CalSTRS by the employer. CalSTRS must receive this form within 60 days after the employee’s signature date and, if applicable, prior to the submission of contributions.

Secure Employer Website:
Send the completed form to the ES Forms Queue found in the Business Areas dropdown of the Recipient via SEW.

Email to:
Submit this form via email to the esforms@calstrs.com mailbox unless otherwise instructed by your CalSTRS representative. If sending forms to the esforms@calstrs.com mailbox, please remove all Social Security numbers and only provide the Client ID where applicable.

Mail to:
CalSTRS
P.O. Box 15275, MS 17
Sacramento, CA 95851-0275

QUESTIONS
Employee – contact your employer

Employer – contact CalSTRS Employer Help
PERMISSIVE MEMBERSHIP ELECTION AND/OR ACKNOWLEDGEMENT OF RECEIPT OF CALSTRS DEFINED BENEFIT PROGRAM MEMBERSHIP INFORMATION

This form is used to permissively elect membership in the CalSTRS Defined Benefit Program and/or to acknowledge receipt of information provided by an employer about the right to elect membership in the CalSTRS Defined Benefit Program. Please read all instructions before completing the form.

Section 1: Employee Information (to be completed by employee)

Provide either your CalSTRS Client ID or Social Security number.

CLIENT ID

SOCIAL SECURITY NUMBER

LAST NAME

FIRST NAME

MI

ADDRESS (number, street, apt or suite no.)

CITY

STATE

ZIP CODE

DATE OF BIRTH (MM/DD/YYYY)

EMAIL ADDRESS

TELEPHONE

Section 2: Employee Election (to be completed by employee)

Check One:

☐ I elect membership in the CalSTRS Defined Benefit Program as of: ________________________ MEMBERSHIP DATE (MM/DD/YYYY)**

I understand this election applies to all future creditable service performed for any current or future employer unless another election is made as allowed by law. I understand my membership is irrevocable and may only be cancelled by terminating all employment to perform creditable service and receiving a refund of my accumulated retirement contributions from the CalSTRS Defined Benefit Program.

**Membership Date may be no earlier than the first day of the pay period in which the election is made, or the first day of employment, whichever is later. Please work with your employer to select the most beneficial, valid membership date.

☐ I decline membership in the CalSTRS Defined Benefit Program at this time

I understand that I can elect membership in the CalSTRS Defined Benefit Program at any time while I am employed to perform creditable service.
**Section 3: Required Signature (to be completed by employee)**

I certify that I have received information from my employer concerning the CalSTRS Defined Benefit Program and understand the criteria for membership in the program.

I understand it is a crime to fail to disclose a material fact or to make any knowingly false material statement, including a false statement regarding my marital status, for the purpose of using it, or allowing it to be used, to obtain, receive, continue, increase, deny or reduce any benefit administered by CalSTRS and it may result in penalties, including restitution, of up to one year in jail and/or a fine of up to $5,000 (Education Code section 22010). It may also result in any document containing such false representation being voided. I certify under penalty of perjury under the laws of the State of California that the foregoing is true and correct. I understand that perjury is punishable by imprisonment for up to four years (Penal Code section 126).

<table>
<thead>
<tr>
<th>EMPLOYEE SIGNATURE</th>
<th>DATE (MM/DD/YYYY)</th>
</tr>
</thead>
</table>

**Section 4: Employee Position Information (to be completed by employer)**

<table>
<thead>
<tr>
<th>POSITION TITLE</th>
<th>POSITION HIRE DATE</th>
</tr>
</thead>
</table>

**Section 5: Employer Information and Certification (to be completed by employer)**

**Required Signature**

I certify that the above-named employee was provided information about their right to elect membership in the CalSTRS Defined Benefit Program and, if electing membership, is eligible to elect membership in the CalSTRS Defined Benefit Program as of the membership date provided.

I understand it is a crime to fail to disclose a material fact or to make any knowingly false material statement for the purpose of using it, or allowing it to be used, to obtain, receive, continue, increase, deny or reduce any benefit administered by CalSTRS and it may result in penalties, including restitution, of up to one year in jail and/or a fine of up to $5,000 (Education Code section 22010). It may also result in any document containing such false representation being voided. I certify under penalty of perjury under the laws of the State of California that the foregoing is true and correct. I understand that perjury is punishable by imprisonment for up to four years (Penal Code section 126).

<table>
<thead>
<tr>
<th>EMPLOYER OFFICIAL’S SIGNATURE</th>
<th>DATE (MM/DD/YYYY)</th>
</tr>
</thead>
<tbody>
<tr>
<td>EMPLOYER NAME</td>
<td>COUNTY AND DISTRICT CODE</td>
</tr>
<tr>
<td>EMPLOYER OFFICIAL’S NAME AND TITLE</td>
<td></td>
</tr>
</tbody>
</table>
I acknowledge that I am required to attend a New Hire Orientation with a representative from Human Resources. I further acknowledge that I have completed the employee new hire forms with information that is true and correct to the best of my knowledge.

Got to the Fowler Unified School District Webpage, under the Human Resources section, (https://www.fowlerusd.org/Page/4051) and review the following mandated documents. Hard copies of the Mandated Notices are also available in the Human Resources Office (658 East Adams Avenue, Fowler). I acknowledge my obligation to read, understand and comply with the content and directives.

A. Child Abuse Educator’s Responsibilities
B. Sexual Molestation and Abuse Prevention Manual
C. Code of Ethics (Board Policy 4119.21/4219.21/4319.21-Professional Standards)
D. Safety
   1. FUSD Employee Safety Handbook – Safety Matters
   2. Bloodborne Pathogen Exposure Control Plan
   3. Instructions for Injured Worker
   4. Drug and Alcohol Free Workplace
   5. Workplace Injury and Illness Prevention Plan
E. Fraud Hotline for Workers Compensation
F. Sexual Harassment Handbook for Employees and Supervisors
G. Workers’ Compensation Information
H. Uniform Complaint Procedures
I. Legal Info. And Required Notices (not limited to..)
   1. DFEH Rights Obligations Pregnant
   2. DFEH Work Place Discrimination Harassment Poster
   3. Discrimination is against the law poster
   4. Rights of Victims Violence, Sexual Assault and Stalking
   5. Sexual Harassment Poster
   6. Time Off to Vote
   7. Transgender Rights in the Workplace Poster
J. Employee Use of Technology Agreement
K. New Health Insurance Marketplace Coverage Options and your Health Coverage
L. Disaster Service Worker Guidelines
M. Federal & California Labor Law Poster
N. School Calendar
O. Classified Calendar (if applicable)

Print Name: ________________________________

Employee Signature: _________________________

Date: ________________________________
MANDATED REPORTER  
ACKNOWLEDGMENT OF MANDATED REPORTING REQUIREMENTS, RECEIPT OF TRAINING, AND RECEIPT OF PENAL CODE STATUTES

A mandated reporter is an individual who is obligated by law to report suspected cases of child abuse and neglect. In general, any individual who, in the ordinary course of their employment, has contact with children is a mandated reporter. Mandated reporters include child care workers, teachers and coaches. (California Penal Code § 11165.7.)

If your job duties as an employee or an independent contractor of the Fowler Unified School District include contact with children, you are a Mandated Reporter. Prior to commencing employment and as a prerequisite of that employment, California law requires that you sign a statement to the effect that you have knowledge of the provisions of the Mandated Reporter Law, and will comply with those provisions. (California Penal Code § 11166.5.)

The following are your Mandated Reporter responsibilities under California law. You are also being provided with a separate informational document which includes the text of the California Mandated Reporter Law and contact information for Child Abuse and Neglect Reporting for the County of San Mateo. Please review this information carefully and acknowledge your receipt and understanding where indicated. If you have questions or concerns about this form or your Mandated Reporter responsibilities, please contact Human Resources [HR] at (650) 616-7055.

I understand that:

- By virtue of my employment or independent contractor status with the Fowler Unified School District, and because my employment requires me to have contact with children, I am a Mandated Reporter as defined by California Penal Code §11165.7.

- The following situations trigger mandatory reports: a) Physical Abuse (willful harming of a child); b) Sexual Abuse including sexual assault, child exploitation, pornography, and trafficking; c) Severe or General Neglect; and d) Extreme Corporal Punishment (resulting in injury). (Cal. Pen. Code § 11165 et seq.) I further understand that I may, but am not required to, report suspected Emotional Abuse. (Cal. Pen. Code 11166.05.)

- If I reasonably suspect that a child is being abused, I must immediately make a telephone report. I must follow up with a written report within 36 hours. This report may be made to local law enforcement, or County Sheriff’s Department, Probation Department or Child Welfare Agency. (Cal. Pen. Code § 11166(a).)

- If I reasonably suspect that a child is being abused, I must immediately report it to my supervisor or management. My supervisor and I may agree to file a joint report, but I understand that even if my supervisor disagrees with me, if I reasonably suspect that a child is being abused, I must make a report. (Cal. Pen. Code §11166(h).)

- I am not required to, but I may, share information about suspected abuse with my supervisor or management or the parents of the alleged victim.

- When I make a mandated report, I will be required to give my name. However, my identity will be kept confidential unless I either consent to disclosure or if disclosure is made pursuant to a court order. Further, agencies investigating the mandated report may disclose my identity to one another. (Cal. Pen. Code §11167(d).)

- The following agencies and individuals receiving or investigating mandated reports may disclose my identity to one another:
• Prosecutors in a criminal prosecution or in an action initiated under section 602 of the Welfare and Institutions Code arising from alleged child abuse;

• Counsel appointed pursuant to subdivision (c) of Section 317 of the Welfare and Institutions Code;

• The county counsel or prosecutor in a proceeding under Part 4 (commencing with Section 7800) of Division 12 of the Family Code or Section 300 of the Welfare and Institutions Code;

• A licensing agency when abuse or neglect in out-of-home care is reasonably suspected. (Cal. Pen. Code § 1167.5.)

• I may not be disciplined, dismissed, retaliated against, discriminated against or harassed for making a mandated report of reasonably suspected child abuse.

• As a Mandated Reporter, I have civil and criminal immunity when making a report. (Cal. Pen. Code § 11172.)

• As a Mandated Reporter, it is a misdemeanor to fail to comply with Mandated Reporting laws and I can be held criminally liable for failing to report suspected abuse. The penalty for this is up to six months in County jail, a fine of not more than $1000, or both. I further understand I could be civilly liable for failure to report. (Cal. Pen. Code § 11166(c).)

I have been provided with a copy of California Penal Code sections 11164-11174.3 (Mandated Reporter Law).

I understand that I am a legally Mandated Reporter. I am aware of and understand my responsibilities under the Mandated Reporter laws of this state and am willing and able to comply. I understand that a copy of this Acknowledgement will be kept in my personnel file.

_________________________________________  ________________________________
Name (Signature)                           Date

_________________________________________
Name (Print)
ACCEPTABLE USE AGREEMENT

AND RELEASE OF DISTRICT FROM LIABILITY (EMPLOYEES)

The Fowler Unified School District authorizes district employees to use technology owned or otherwise provided by the district as necessary to fulfill the requirements of their position. The use of district technology is a privilege permitted at the district's discretion and is subject to the conditions and restrictions set forth in applicable Board policies, administrative regulations, and this Acceptable Use Agreement. The district reserves the right to suspend access at any time, without notice, for any reason.

The district expects all employees to use technology responsibly in order to avoid potential problems and liability. The district may place reasonable restrictions on the sites, material, and/or information that employees may access through the system.

The district makes no guarantee that the functions or services provided by or through the district will be without defect. In addition, the district is not responsible for financial obligations arising from unauthorized use of the system.

Each employee who is authorized to use district technology shall sign this Acceptable Use Agreement as an indication that he/she has read and understands the agreement.

Definitions

District technology includes, but is not limited to, computers, the district's computer network including servers and wireless computer networking technology (wi-fi), the Internet, email, USB drives, wireless access points (routers), tablet computers, smartphones and smart devices, telephones, cellular telephones, personal digital assistants, pagers, MP3 players, wearable technology, any wireless communication device including emergency radios, and/or future technological innovations, whether accessed on or off site or through district-owned or personally owned equipment or devices.

Employee Obligations and Responsibilities

Employees are expected to use district technology safely, responsibly, and primarily for work-related purposes. Any incidental personal use of district technology shall not interfere with district business and operations, the work and productivity of any district employee, or the safety and security of district technology. The district is not responsible for any loss or damage incurred by an employee as a result of his/her personal use of district technology.

The employee in whose name district technology is issued is responsible for its proper use at all times. Employees shall not share their assigned online services account information, passwords, or other information used for identification and authorization purposes, and shall use the system only under the account to which they have been assigned. Employees shall not gain unauthorized access to the files or equipment of others, access electronic resources by using another person's name or electronic identification, or send anonymous electronic communications. Furthermore, employees shall not attempt to access any data, documents, emails, or programs in the district's system for which they do not have authorization.

Employees are prohibited from using district technology for improper purposes, including, but not limited to, use of district technology to:
1. Access, post, display, or otherwise use material that is discriminatory, defamatory, obscene, sexually explicit, harassing, intimidating, threatening, or disruptive

2. Disclose or in any way cause to be disclosed confidential or sensitive district, employee, or student information without prior authorization from a supervisor

3. Engage in personal commercial or other for-profit activities without permission of the Superintendent or designee

4. Engage in unlawful use of district technology for political lobbying

5. Infringe on copyright, license, trademark, patent, or other intellectual property rights

6. Intentionally disrupt or harm district technology or other district operations (such as destroying district equipment, placing a virus on district computers, adding or removing a computer program without permission, changing settings on shared computers)

7. Install unauthorized software

8. Engage in or promote unethical practices or violate any law or Board policy, administrative regulation, or district practice

Privacy

Since the use of district technology is intended for use in conducting district business, no employee should have any expectation of privacy in any use of district technology.

The district reserves the right to monitor and record all use of district technology, including, but not limited to, access to the Internet or social media, communications sent or received from district technology, or other uses within the jurisdiction of the district. Such monitoring/recording may occur at any time without prior notice for any legal purposes including, but not limited to, record retention and distribution and/or investigation of improper, illegal, or prohibited activity. Employees should be aware that, in most instances, their use of district technology (such as web searches or emails) cannot be erased or deleted.

All passwords created for or used on any district technology are the sole property of the district. The creation or use of a password by an employee on district technology does not create a reasonable expectation of privacy.

Personally Owned Devices

If an employee uses a personally owned device to access district technology or conduct district business, he/she shall abide by all applicable Board policies, administrative regulations, and this Acceptable Use Agreement. Any such use of a personally owned device may subject the contents of the device and any communications sent or received on the device to disclosure pursuant to a lawful subpoena or public records request.

Records

Any electronically stored information generated or received by an employee which constitutes a district or student record shall be classified, retained, and destroyed in accordance with BP/AR 3580 - District
Records, BP/AR 5125 - Student Records, or other applicable policies and regulations addressing the retention of district or student records.

Reporting

If an employee becomes aware of any security problem (such as any compromise of the confidentiality of any login or account information) or misuse of district technology, he/she shall immediately report such information to the Superintendent or designee.

Consequences for Violation

Violations of the law, Board policy, or this Acceptable Use Agreement may result in revocation of an employee's access to district technology and/or discipline, up to and including termination. In addition, violations of the law, Board policy, or this agreement may be reported to law enforcement agencies as appropriate.

Employee Acknowledgment

I have received, read, understand, and agree to abide by this Acceptable Use Agreement, BP 4040 - Employee Use of Technology, and other applicable laws and district policies and regulations governing the use of district technology. I understand that there is no expectation of privacy when using district technology or when my personal electronic devices use district technology. I further understand that any violation may result in revocation of user privileges, disciplinary action, and/or appropriate legal action.

I hereby release the district and its personnel from any and all claims and damages arising from my use of district technology or from the failure of any technology protection measures employed by the district.

Name: _______________________________ Position:

(Please print)

School/Work Site:

Signature: _______________________________ Date:
Drug- and Alcohol-Free Workplace
Notice to Employees

YOU ARE HEREBY NOTIFIED that it is a violation of Board policy for any employee at a school district workplace to unlawfully manufacture, distribute, dispense, posses, use or be under the influence of any alcoholic beverage, drug or controlled substance as defined in the Controlled Substances Act and Code of Federal Regulations.

“School district workplace” is defined as any place where school district work is performed, including a school building or other school premises; any school-owned or school-approved vehicle used to transport students to and from school or school activities; any off-school sites when accommodating a school-sponsored or school-approved activity or function, such as a field trip or athletic event, where students are under district jurisdiction; or during any period of time when an employee is supervising students on behalf of the district or otherwise engaged in district business.

As a condition of your continued employment with the district, you will comply with the district’s policy on Drug- and Alcohol-Free Workplace and will, any time you are convicted of any criminal drug or alcohol statute violation occurring in the workplace, notify your supervisor of this conviction no later than five days after such conviction.

Pursuant to California Education Code 44836 and 45123, the Board may not employ or retain in employment person 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.

Pursuant to Education Code 45123, the district may employ for classified service a person who has been convicted of a controlled substance offense only if it determines, from evidence presented, that the person has been rehabilitated for at least five years. The Board shall determine the type and manner of presentation of the evidence, and the Board’s determination as to whether or not the person has been rehabilitated is final.

Pursuant to Education Code 44940 and 45304, the district must immediately place on compulsory leave of absence any employee charged with involvement in the sale, use or exchange to minors of certain controlled substances.

Pursuant to Education Code 44940 and 45304, the district may immediately place on compulsory leave of absence any employee charged with certain controlled substance offenses.

The following drug and alcohol counseling, rehabilitation and/or employee assistance programs are available locally:

   Halcyon Employee Assistance Program – (888) 425-4800

   Central California Recovery

   Fresno County Hispanic Commission on Alcohol & Drug Abuse Services

   Kings View Community Service

I acknowledge receipt of the Drug- and Alcohol-Free Workplace Notice to Employees. I also understand that I may keep a copy of this for my future reference.

Employee Name: __________________________ Signature: __________________________ Date: ___
Oath or Affirmation of Allegiance
Civil Defense Workers and Public Employees

(Section 3100, 3102 and 3103, Government Code of California)

FOWLER UNITED SCHOOL DISTRICT

STATE OF CALIFORNIA
COUNTY OF FRESNO

As an officer, member or employee of FOWLER UNIFIED SCHOOL DISTRICT

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

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

Employee’s Signature: ____________________________________________ Date: _____________________

FOR OFFICE USE ONLY

Subscribed and sworn to before me this_________day of__________________, 20_________.

__________________________________________
Human Resources Representative
Statement Concerning Your Employment in a Job
Not Covered by Social Security

Employee Name
Employee SSN#  

Employer Name: Fowler Unified School District  Employer ID# 77-0559743

Your earnings from this job are not covered under Social Security. When you retire, or if you become disabled, you may receive a pension based on earnings from this job. If you do, and you are also entitled to a benefit from Social Security based on either your own work or the work of your husband or wife, or former husband or wife, your pension may affect the amount of the Social Security benefit you receive. Your Medicare benefits, however, will not be affected. Under the Social Security law, there are two ways your Social Security benefit amount may be affected.

Windfall Elimination Provision
Under the Windfall Elimination Provision, your Social Security retirement or disability benefit is figured using a modified formula when you are also entitled to a pension from a job where you did not pay Social Security tax. As a result, you will receive a lower Social Security benefit than if you were not entitled to a pension from this job. For example, if you are age 62 in 2005, the maximum monthly reduction in your Social Security benefit as a result of this provision is $313.50. This amount is updated annually. This provision reduces, but does not totally eliminate, your Social Security benefit. For additional information, please refer to Social Security Publication, “Windfall Elimination Provision.”

Government Pension Offset Provision
Under the Government Pension Offset Provision, any Social Security spouse or widow(er) benefit to which you become entitled will be offset if you also receive a Federal, State or local government pension based on work where you did not pay Social Security tax. The offset reduces the amount of your Social Security spouse or widow(er) benefit by two-thirds of the amount of your pension.

For example, if you get a monthly pension of $600 based on earnings that are not covered under Social Security, two-thirds of that amount, $400, is used to offset your Social Security spouse or widow(er) benefit. If you are eligible for a $500 widow(er) benefit, you will receive $100 per month from Social Security ($500 - $400=$100). Even if your pension is high enough to totally offset your spouse or widow(er) Social Security benefit, you are still eligible for Medicare at age 65. For additional information, please refer to Social Security Publication, “Government Pension Offset.”

For More Information
Social Security publications and additional information, including information about exceptions to each provision, are available at www.socialsecurity.gov. You may also call toll free 1-800-772-1213, or for the deaf or hard of hearing call the TTY number 1-800-325-0778, or contact your local Social Security office.

I certify that I have received Form SSA-1945 that contains information about the possible effects of the Windfall Elimination Provision and the Government Pension Offset Provision on my potential future Social Security benefits.

Signature of Employee
Date

Form SSA-1945 (12-2004)
Information about Social Security Form SSA-1945
Statement Concerning Your Employment in a Job Not Covered by Social Security

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

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

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

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

Copies of the SSA-1945 are available online at the Social Security website, [www.socialsecurity.gov/form1945](http://www.socialsecurity.gov/form1945). Paper copies can be requested by email at oplm.oswm.rqct.orders@ssa.gov or by fax at 410-965-2037. The request must include the name, complete address and telephone number of the employer. Forms will not be sent to a post office box. Also, if appropriate, include the name of the person to whom the forms are to be delivered. The forms are available in packages of 25. Please refer to Inventory Control Number (ICN) 276950 when ordering.