SAN MARCOS UNIFIED SCHOOL DISTRICT

CONGRATULATIONS!
You have been offered a Certificated position with San Marcos Unified School District.

The following documents make up your required new-hire packet. Please complete the top portion of the "New Hire Information" page carefully. This page will automatically populate many of the fields on the subsequent pages, but you will still need to read each page carefully to ensure that your packet is filled out completely. Please print your documents, and be certain to sign all pages, as needed.

You will also need to take the online Mandated Reporter Training. To complete the training, follow this link: http://educators.mandatedreporterca.com/. Please choose the **GENERAL TRAINING OPTION ONLY**. Upon successful completion of the training, you will receive an email with your Certificate. Please bring this Certificate to HR with your New-Hire Packet.

REMEMBER TO BRING THESE REQUIRED ITEMS to HUMAN RESOURCES:

- ✓ **Your completed New-Hire Packet**
- ✓ **All Transcripts (if Official Transcripts are not available yet, bring Unofficial Transcripts for now)**
- ✓ **Social Security Card**
- ✓ **Driver's License**
- ✓ **TB test results**
- ✓ **Proof of COVID Vaccine**
- ✓ **Mandated Reporter Training Certificate**

To aid in gathering all documents, please utilize the Checklist that we have provided at the end of the packet. Incomplete packets will delay the hiring process for you.

BRING ALL NEW HIRE FORMS TO HUMAN RESOURCES *****NO APPOINTMENT IS NECESSARY*****

Bring all requested items as soon as possible to Human Resources.
Upon receipt, we will release your Pre-Employment Physical and LiveScan authorizations, which you will take to WorkPartners in Vista.
You will be responsible for paying Workpartners your LiveScan fee of $74.

Once we receive your Physical and LiveScan results, we will then invite you to your Pre-Employment Processing Appointment to complete the New Hire rocess.

If you have any questions prior to dropping off new hire forms, please don't hesitate to contact Heather Lowery at 760-752-1243 or Amber Christman at 760-752-1244.

Welcome to the San Marcos Unified School District!

To help prepare you for your first year with our district, we want to make you aware of upcoming District events for our new hires.

All new Certificated personnel are invited to attend
the **New Teacher Orientation**

TBD (District Office Comm Labs Rooms 1-4-Follow the signs)

This morning orientation will acquaint you with many of the District policies and resources, and a number of District departments will present valuable information to you at this event.

Essential Elements of Instruction (EEI)
and
Classroom Behavior Management

As a new teacher with the District, you will also be required to attend a two year series of seminars, including the Essential Elements of Instruction (EEI) and Classroom Behavior Management. This mandatory program includes 37.5 hours of staff development to assist you in learning our District's model of instruction.

Please note, the first seminar, Classroom Behavior Management, will be held prior to the start of school on

TBD District Office (Comm Labs Rooms 1-4-Follow the signs)

You will receive a complete EEI schedule and further information at your Pre-Employment Processing Appointment with Human Resources.

Please feel free to contact Amber Christman (Amber.Christman@smusd.org) or Heather Lowery (Heather.Lowery@smusd.org) if you need any further information.

We look forward to an exciting and successful new year!

SAN MARCOS UNIFIED SCHOOL DISTRICT
engaging students...inspiring futures

San Marcos Unified School District
Human Resources
New Hire Information

Last Name _____ First Name _____ Middle _____

Street Address _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

Social Security Number _____ Date of Birth _____

E-mail _____ AESOP Log-in ○ Use Home Phone ○ Use Cell Phone

Emergency Contact _____ Relation _____

Home Phone or n/a _____ Cell Phone or n/a _____

Address _____ City _____ State _____ Zip _____

Signature _____ Date _____

HUMAN RESOURCES USE ONLY

Hire Date _____ Site _____ FTE _____

Position _____ Position # _____ Employee ID _____

Credential #1 _____ Expiration _____

Credential #2 _____ Expiration _____

REQ # _____ Degree _____

Years Experience _____ Post BA Semester Units _____ Salary Placement _____

Rec'd in HR:
- ☐ DL
- ☐ SS
- ☐ TB / Expiration Date_____
- ☐ Physical
- ☐ DOJ Clear

W-4 ☐ Married ☐ Single

Sex ☐ Male ☐ Female

CERTIFICATED NEW HIRE PROCESSING INFORMATION

In order for Human Resources to process certificated new hires for payroll, the following information must be submitted immediately. Please review this list and check off each item verifying you have completed each task.

☐ **Order Official Transcripts:** You will need to submit official transcripts showing your BA and post BA units. Have them sent to:

San Marcos Unified School District,
Attention: Amber Christman /Human Resources
255 Pico Avenue, Suite 250, San Marcos, CA 92069

If you have official transcripts in your personal file, we will accept them as long as they have the university seal on them.

☐ **List ALL official transcripts that we should expect to receive**:

UNIVERSITY NAME Units:	BA	Post BA

UNIVERSITY NAME: Units:	BA	Post BA

☐ **For initial salary schedule placement, I know that I have _____ semester units above my BA at the time of hire**.

NOTE: Quarter units need to be converted to semester units (1 quarter unit = 2/3 semester unit).

- *I know that I will initially be processed in SMUSD based on this information in the event my official transcripts have not arrived.*

◯◯ YES N/A **I have a Masters Degree and I will submit official transcripts verifying this.**

Degree_____ Conferral Date _____

◯◯ YES N/A **Number of years Full Time, Contracted, Certificated experience** _____

***IMPORTANT PLEASE READ**: In order to receive a full year of credit for salary placement, you must have been contracted, worked over 75% of that school year, and shall have maintained a valid credential during that year of service, Substitute experience, part-time positions less than 75% and non contracted experience cannot be counted for salary placement.*

◯◯ YES N/A **Verification of previous full time teaching experience**: SMUSD will verify your previous experience. Please list the District names and addresses below:

From: To:	District Name	District Address

◯◯ YES N/A **TRANSFER OF SICK LEAVE:** SMUSD will request transfer of your sick leave if you were previously employed in another California School District.

- *Please give the correct name & address of the last California School District where you were employed.*

District Name	District Address

_____ _____ _____

Print Name Signature Date

SAN MARCOS UNIFIED SCHOOL DISTRICT
engaging students...inspiring futures

Human Resources and Development
255 Pico Avenue, Suite 250
San Marcos, CA 92069

T 760.752.1299
F 760.752.1138
www.smusd.org

Date: _____ Requested by: *Heather Lowery – Heather.Lowery@smusd.org, (760) 752-1243*
Human Resources -Human Resources Support Technician

VERIFICATION OF CERTIFICATED EXPERIENCE

To: *Human Resources - Certificated Personnel*

School District: _____

Employee Name: _____ ***SS #:*** xxx-xx- _____

I have been appointed to a certificated position in the San Marcos Unified School District. Will you please verify my experience in your district and **return this form within five days** to:

San Marcos Unified School District
Attn: Human Resources - Certificated
255 Pico Ave., Suite 250
San Marcos, CA 92069

Authorization to Release Information Granted By:

Employee Signature: _____ Date: _____

DISTRICT VERIFICATION ONLY BELOW THIS LINE

Please verify contracted, certificated experience in your district below. Use one line for each year of service.

School Year	Position	FTE %	From	To	Days Worked	Contracted Days

Signature: _____ **Date:** _____

Printed Name: _____ **Title:** _____

School District: _____ **Phone:** _____ **Ext.:** _____

School District Address: _____ **Email:** _____

SAN MARCOS UNIFIED SCHOOL DISTRICT
engaging students...inspiring futures

Human Resources and Development
255 Pico Avenue, Suite 250
San Marcos, CA 92069

T 760.752.1299
F 760.752.1138
www.smusd.org

Date: _____ Requested by: *Heather Lowery- Heather.Lowery@smusd.org, (760) 752-1243*
Human Resources - Human Resources Support Technician

TRANSFER OF ACCUMULATED SICK LEAVE

To: *Human Resources - Certificated Personnel*

School District: _____

Employee Name: _____ ***SS #:*** xxx-xx- _____

I have been appointed to a certificated position in the San Marcos Unified School District. In compliance with Education Codes regarding the transfer of sick leave from other California school districts, please complete and return this form as soon as possible to:

San Marcos Unified School District
Attn: Human Resources - Certificated
255 Pico Ave., Suite 250
San Marcos, CA 92069

Authorization to Release Information Granted By:

Employee Signature: _____ Date: _____

DISTRICT VERIFICATION ONLY BELOW THIS LINE

School District: _____

Dates of Service: From: _____ **To:** _____

Unused sick leave HOURS accumulated at the time of transfer from your district:

Number of HOURS: _____

CERTIFIED BY:

Signature: _____ **Date:** _____

Printed Name: _____ **Title:** _____

Phone: _____ **Ext.:**_____ **Email:** _____

School District Name: _____

School District Address: _____

Employment Eligibility Verification

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

USCIS
Form I-9
OMB No. 1615-0047
Expires 08/31/2019

▶**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.)*

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

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

Date of Birth *(mm/dd/yyyy)*	U.S. Social Security Number	Employee's E-mail Address	Employee's Telephone Number
	☐☐☐ - ☐☐ - ☐☐☐☐		

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

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

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

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: _____

QR Code - Section 1
Do Not Write In This Space

Signature of Employee	Today's Date *(mm/dd/yyyy)*

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.

Signature of Preparer or Translator	Today's Date *(mm/dd/yyyy)*

Last Name *(Family Name)*	First Name *(Given Name)*

Address *(Street Number and Name)*	City or Town	State	ZIP Code

STOP *Employer Completes Next Page* STOP

Employment Eligibility Verification

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

USCIS
Form I-9
OMB No. 1615-0047
Expires 08/31/2019

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.")

Employee Info from Section 1	Last Name *(Family Name)*	First Name *(Given Name)*	M.I.	Citizenship/Immigration Status

List A Identity and Employment Authorization	OR	List B Identity	AND	List C Employment Authorization
Document Title		Document Title: California DL		Document Title: Social Security Card
Issuing Authority		Issuing Authority: CA DMV		Issuing Authority: SSA
Document Number		Document Number		Document Number
Expiration Date *(if any)(mm/dd/yyyy)*		Expiration Date *(if any)(mm/dd/yyyy)*		Expiration Date *(if any)(mm/dd/yyyy)*
Document Title				
Issuing Authority				
Document Number				
Expiration Date *(if any)(mm/dd/yyyy)*				
Document Title				
Issuing Authority				
Document Number				
Expiration Date *(if any)(mm/dd/yyyy)*				

Additional Information

QR Code - Sections 2 & 3
Do Not Write In This Space

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

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

Signature of Employer or Authorized Representative	Today's Date *(mm/dd/yyyy)*	Title of Employer or Authorized Representative
		CERTIFICATED PERSONNEL TECHNICIAN

Last Name of Employer or Authorized Representative	First Name of Employer or Authorized Representative	Employer's Business or Organization Name
CHRISTMAN	AMBER	SAN MARCOS UNIFIED SCHOOL DISTRICT

Employer's Business or Organization Address (Street Number and Name)	City or Town	State	ZIP Code
255 PICO AVE., STE. 250	SAN MARCOS	CA	92069

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

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

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.

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

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

Signature of Employer or Authorized Representative	Today's Date *(mm/dd/yyyy)*	Name of Employer or Authorized Representative

LISTS OF ACCEPTABLE DOCUMENTS
All documents must be UNEXPIRED

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

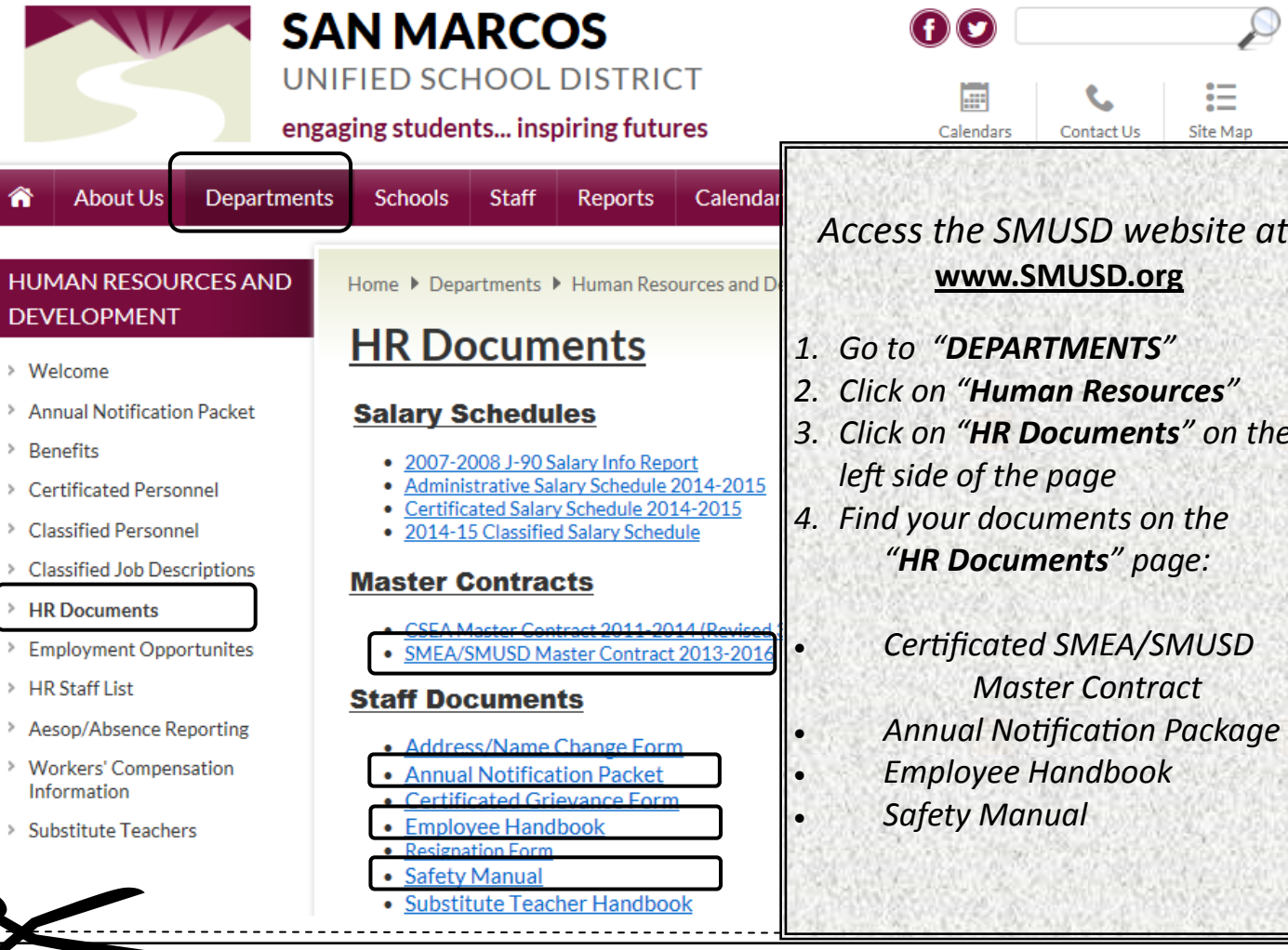
LIST A Documents that Establish Both Identity and Employment Authorization	OR	LIST B Documents that Establish Identity	AND	LIST C Documents that Establish Employment Authorization
1. U.S. Passport or U.S. Passport Card		1. Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		1. A Social Security Account Number card, unless the card includes one of the following restrictions: (1) NOT VALID FOR EMPLOYMENT (2) VALID FOR WORK ONLY WITH INS AUTHORIZATION (3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION
2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)		2. ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		2. Certification of Birth Abroad issued by the Department of State (Form FS-545)
3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa		3. School ID card with a photograph		3. Certification of Report of Birth issued by the Department of State (Form DS-1350)
4. Employment Authorization Document that contains a photograph (Form I-766)		4. Voter's registration card		4. Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal
5. For a nonimmigrant alien authorized to work for a specific employer because of his or her status: a. Foreign passport; and b. Form I-94 or Form I-94A that has the following: (1) The same name as the passport; and (2) An endorsement of the alien's nonimmigrant status as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form.		5. U.S. Military card or draft record		5. Native American tribal document
		6. Military dependent's ID card		6. U.S. Citizen ID Card (Form I-197)
		7. U.S. Coast Guard Merchant Mariner Card		7. Identification Card for Use of Resident Citizen in the United States (Form I-179)
		8. Native American tribal document		8. Employment authorization document issued by the Department of Homeland Security
		9. Driver's license issued by a Canadian government authority		
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		**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 Part 8 of the Handbook for Employers (M-274).

Refer to the instructions for more information about acceptable receipts.

SAN MARCOS UNIFIED SCHOOL DISTRICT

www.SMUSD.org



Access the SMUSD website at:
www.SMUSD.org

1. *Go to "**DEPARTMENTS**"*
2. *Click on "**Human Resources**"*
3. *Click on "**HR Documents**" on the left side of the page*
4. *Find your documents on the "**HR Documents**" page:*

- *Certificated SMEA/SMUSD Master Contract*
- *Annual Notification Package*
- *Employee Handbook*
- *Safety Manual*

SMUSD POLICY ACKNOWLEDGEMENT

I understand that I am legally obligated to review the following policies:

- **Certificated SMEA/SMUSD Master Contract**
- **Employee Handbook**
- **Safety Manual**

on the San Marcos Unified School District website:
www.SMUSD.org

I understand how to access and have reviewed the district policies / documents listed above

_____
Employee Name (please print)

_____ _____
Employee Signature Date

RECEIVING CREDIT FOR SALARY MOVEMENT AFTER HIRE

COURSE APPROVAL FORMS

All Course Approval Forms are available in your school site office*

Please refer to the SMEA/SMUSD Master Contract Article X Section 3: Credit for College and University Training. You will need to complete a Course Approval Application form for every course you wish to receive unit credit. Send the completed Course Approval Form to Amber Christman/HR. These forms should be submitted prior to taking coursework. A Professional Growth Committee that has been selected by SMEA will review this Course Approval Application form and either approve or disapprove it. The Human Resources Department will return the yellow copy of the Course Approval Form to you so that you can see the Professional Growth Committee's action.

REQUEST FOR RECLASSIFICATION FORM

Please refer to the SMEA/SMUSD Master Contract Article X, Section 3 B: Movement on the salary schedule. Movement down a step every year is automatically done, Column movement is not. It is your responsibility to notice the district of your intent to make a column change for the next school year. You have until March 1st of each year to notice the district of your intent to change columns for the upcoming school year. You will use the Request for Reclassification form in order to request a column change.

All Request for Reclassification Forms are available in your school site office*

SMEA/SMUSD Master Contract
ARTICLE X: SALARY
Section 3: Credit for College and University Training

The following criteria shall govern the crediting of Salary Schedule columnar provisions:

A. Credit for salary purposes cannot be given for any course work taken without the written approval of the Professional Growth Committee.
B. The employee shall submit by March 1 a District Reclassification Form to the Human Resources and Development Department expressing the intent to change salary columns.
C. Except as provided herein, in order to receive salary schedule credit, an employee must present an official transcript or documented grade report.
D. The unit requirement for each salary column is stated in semester hours of credit, quarter-hour credits shall be computed into semester hours by multiplying quarter units by 2/3.
E. For salary schedule purposes, only semester units, as described herein, earned after the confirmation of the Bachelor's Degree shall be credited.
F. Units to be applied for current year salary schedule credit shall:
    1. Be completed prior to the start of a school year; and
    2. Be verified in the Human Resources and Development Department with official transcripts by November 1 of the current school year.
G. Credit shall not be granted for any course in which less than a "C" grade (or "pass" if a pass/fail grading system is used by a college) is earned by the employee.
H. All units and degrees shall be earned from institutions accredited by the American Association of Schools and Colleges, or regional affiliate.
I. A major field of preparation shall be defined as twenty-four (24) semester hours; a minor field of study shall be defined as twenty (20) semester hours.
J. Upper division or graduate courses that may be credited:
    1. A subject directly related to the employee's present or proposed assignment.
    2. A subject directly related to an employee's major or minor field of preparation.
    3. A subject directly related to, or required for, an advanced degree in professional education or the employee's assignment or major or minor fields of preparation.
    4. A subject required by a California credential, evaluation or renewal.
    5. A subject commonly taught in the elementary schools by an employee in a self-contained classroom program.
    6. Courses in an additional major or minor field of preparation by an employee in a departmentalized classroom program (see K.3 below).
K. Lower division courses that may be credited:
    1. Courses required by a California credential, evaluation or renewal.
    2. A course, not previously taken, that is offered by a teacher training institution and which is directly related to an employee's assignment.
    3. Courses required as a foundation for the acquiring of an additional major or minor field of preparation related to the employee's assignment – such lower division courses to be credited only when the requirements of a full minor preparation have been met.
L. Repeat credit may be granted for a course taken at a teacher training institution in which:
    1. The content field has recently undergone substantial change;
    2. An updating of employee training is desirable.

I have reviewed the details of the Certificated Reclassification process, which is always available online in the SMUSD Certificated Master Contract.

I also understand that it is my responsibility to submit all required forms for the Reclassification process by the deadlines specified in my Certificated Master Contract.

Print Name Signature Date

SAN MARCOS
UNIFIED SCHOOL DISTRICT
engaging students...inspiring futures

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

(Required by Section 3107 Title 1 Government Code)
(State of California, County of San Diego) ss

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

_____
Signature of Employee

Taken, subscribed and sworn to before me this_____ day of _____, 20____.

_____
Signature of Authorized Official

Amber Christman
_____
Certificated Personnel Technician
San Marcos Unified School District
San Marcos, CA 92069

SAN MARCOS UNIFIED SCHOOL DISTRICT

EMPLOYEE'S DESIGNATION OF BENEFICIARY
UNDER GOVERNMENT CODE SECTION 53245*

INSTRUCTIONS: Please complete this form and return it to the Human Resources Department.

From: _____ XXX-XX-_____
Employee Name Social Security Number (Last 4 numbers only)

To: SMUSD Human Resources & Development Department

Re: Designation of Person to Receive and Negotiate Warrants After Death Under Government Code Section 53245

This is to inform you that in the event of my death, I hereby designate:

_____
Name of Designee

as the person entitled to receive and negotiate all warrants or checks that will be payable to me from the Superintendent of Schools, San Diego County Office of Education.

This designee is: ◯ Husband ◯ Wife ◯ Parent ◯ Child ◯ Other_____

He/she may be identified as follows:

_____ _____ XXX – XX - _____
Date of Birth Place of Birth Social Security Number
(Last 4 numbers only)

Address, this date:

I understand that it is my responsibility to keep this designation current, and further, I understand that the designation is in addition to, and separate from, the beneficiary designation filed with the State Teachers' Retirement System, the Public Employees' Retirement System, the County Employees' Retirement System, or in any other will, codicils or like documents.

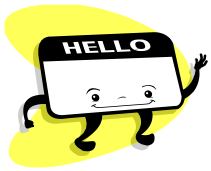
_____ _____
Date Filed Signature

*Government Code, Section 53245

"Any person now or hereafter employed by a county, city, municipal corporation, district or other public agency may file with his appointing power a designation of a person who, notwithstanding any other provision of law, shall, on the death of the employee, be entitled to receive all warrants or checks that would have been payable to the decedent had he survived. The employee may change the designation from time to time. A person so designated shall claim such warrants or checks from the appointing power. On sufficient proof of identity, the appointing power shall deliver the warrants or checks to the claimant. A person who received a warrant or check pursuant to this section is entitled to negotiate it as if he were the payee."

HUMAN RESOURCES

VOLUNTARY INFORMATION FORM



Section 1233 of the California Government Code permits public employers to solicit from employees and applicants a voluntary declaration of sex and racial/ethnic group membership. Information provided will assist the San Marcos Unified School District (SMUSD) in accurately compiling required statistical reports for federal and state agencies. None of the information will be used to discriminate against or give preference to any individual in any personnel transaction. Other information requested is for the SMUSD use only and is also voluntary.

PLEASE PRINT

Full legal name: _____

Position: _____

Birthdate: _____ Gender: _____

School site/Work location: _____

The following questions are required to be in compliance with new Federal/State laws. Please mark the appropriate area:

Ethnicity: *Please mark one box to indicate your ethnicity:*

☐ African American	☐ Filipino	☐ Indian	☐ White
☐ Asian	☐ Hispanic	☐ Pacific Islander	☐ Other

Ethnic Background: Are you Hispanic or Latino? ☐ YES ☐ NO

Race: *Please mark one or more boxes to indicate your race:*

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

Risk Management JPA
Fringe Benefits Consortium

SAN DIEGO COUNTY AND IMPERIAL COUNTY SCHOOLS

EMPLOYEE NOTICE WORKERS' COMPENSATION BENEFITS

This is to acknowledge receipt of information regarding California Workers' Compensation laws and rights in addition to notice regarding the Medical Provider Network that my employer utilizes.

I HAVE READ THE ATTACHED INFORMATION AND UNDERSTAND MY RIGHTS AND BENEFITS UNDER THE WORKERS' COMPENSATION PROGRAM. I AGREE TO REPORT ALL WORK RELATED INJURIES AND ILLNESSES TO MY SUPERVISOR/ EMPLOYER IMMEDIATELY AFTER THEY OCCUR.

EMPLOYEE NAME_____ DATE_____
(PLEASE PRINT)

EMPLOYEE SIGNATURE_____

DISTRICT SAN MARCOS UNIFIED SCHOOL DISTRICT

Link to the San Diego County Schools Employee's Workers' Compensation Handbook:
http://www.sdcoe.net/business-services/risk-management/Documents/WC_Employee_Handbook_Revised_Mar_2015.pdf

6401 Linda Vista Road, #505 • San Diego, CA 92111-7399 • (858) 569-5320 • Fax (858) 279-6236

Form032014

San Marcos Unified School District

workers' compensation: Pre-Designation of Personal Physician

If you have health insurance and you are injured on the job you have the right to be treated immediately by your personal physician (M.D., D.O), or medical group, if you notify your employer, in writing, prior to the injury. Per Labor Code 4600 **to qualify as the your predesignated, personal physician, the physician must agree, in writing, to treat you for a work related injury,** must have previously directed your medical care and must retain your medical history and records. Your predesignated physician must be a family practitioner, general practitioner, board certified or board eligible internist, obstetrician-gynecologist or pediatrician. Your "personal physician" may be a medical group if it is a single corporation or partnership composed of licensed doctors or medicine or osteopathy, which operates an integrated multi-specialty medical group providing comprehensive medical services predominantly for non-occupational illnesses and injuries.

This is an optional form that can be used to notify your employer of your personal physician. You may choose to use another form, as long as you notify your employer, in **writing, prior** to being injured on the job and provide **written verification** that your personal physician meets the above requirements and agrees to be predesignated. Otherwise, you will be treated by one of your employers' designated workers' compensation medical providers.

EMPLOYEE NAME & ADDRESS:

_____

❑ **I acknowledge receipt of this form and elect not** to predesignate my personal physician at this time. I understand that I will receive medical treatment from my employers' medical provider. I understand that, at any time in the future, I can change my mind and provide written notification of my personal physician. I understand that the written notification must be on file prior to an industrial injury.

Employee Signature: _____ Date: _____

❑ **If I am injured on the job, I wish to be treated by my personal physician***:

Name of Physician or Medical Group _____ Phone Number _____

Address _____

*This physician is my personal primary care physician who has previously directed my medical care and retains my medical history and records.

Name of Insurance Company, Plan, or Fund providing health coverage for nonoccupational injuries or illnesses:

_____

Employee Signature: _____ Date: _____

A *Personal Physician* must be willing to be predesignated and treat you for a workers' compensation injury.
The remainder of this form is to be completed by your physician and returned to your Employer.

PERSONAL PHYSICIAN ACKNOWLEDGEMENT

Per Labor Code 4600 to qualify you must meet the criteria outlined above. You are not required to sign this form, however, if you or your designated employee, does not sign, other documentation of the physicians' agreement to be predesignated will be required pursuant to Title 8, California Code of Regulations, section 9780.1(a)(3).

PERSONAL PHYSICIAN OR MEDICAL GROUP NAME: _____

❑ ***I agree to treat*** **the above named employee in the event of an industrial accident or injury.** I meet the criteria outlined above. I agree to adhere to the Administrative Director's Rules and Regulations, Section 9785, regarding the duties of the employee-designated physician.

_____ _____

(Physician or Designated Employee of the Physician or Medical Group) Date

Please return completed form to:

Human Resources/Risk Management 255 Pico Ave., San Marcos, CA 92069 email: Risk.Management@smusd.org or Fax (760) 75-1202

new hire pamphlet

If a work injury occurs

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

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

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

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

Workers' compensation benefits include

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

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

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

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

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

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

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

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

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

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

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

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

MPN Information

Harbor Health Systems MPN Contact
(888) 626-1737
MPNcontact@harborsys.com

How to obtain additional information

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

Department of Workers' Compensation Information and Assistance Offices

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

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

Keenan & Associates adjusting locations

Torrance
800-654-8102

Eureka
707-268-1616

Pleasanton
925-225-0611

Rancho Cordova
800-343-0694

Redwood City
650-306-0616

Riverside
800-654-8347

San Jose
800-334-6554

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

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Folleto de información para los nuevos empleados

Si sufre una lesión de trabajo

Las leyes de California garantizan ciertos beneficios a los empleados que resultan lesionados o se enferman a causa de su trabajo.

Cualquier lesión o enfermedad relacionada con el trabajo está cubierta. Entre los tipos de lesiones se incluyen, sin limitarse, torceduras, esguinces, cortaduras, traumas cumulativos o repetitivos, fracturas, enfermedades y agravamientos. Algunas lesiones de actividades voluntarias, fuera de turno, recreativas, sociales o atléticas puede que no estén cubiertas. Si tiene alguna pregunta consulte con su supervisor o con Keenan & Associates.

Todas las lesiones relacionadas con el trabajo deben ser reportadas a su supervisor inmediatamente. No espere, hay un límite de tiempo para reportarlas. Si espera demasiado, puede perder su derecho a recibir beneficios. Su empleador tiene la obligación de darle un formulario de reclamos dentro de un día laboral desde que se enteró de su lesión.

Es un delito menor que un empleador discrimine a trabajadores que se lesionaron en el trabajo o que testifiquen en el caso de otro empleado. Cualquier empleado en esas circunstancias puede tener derecho a una indemnización, restitución y reembolso por la pérdida de ingresos y beneficios.

Los beneficios de compensación a los trabajadores incluyen

Atención médica – Todo tratamiento médico sin deducible ni cantidad límite. Para lesiones sufridas con fechas de o posteriores al 01/01/04 hay un límite de 24 visitas quiroprácticas, 24 visitas de terapia física y 24 visitas de terapia ocupacional.

Sin embargo, este límite no se aplica a los tratamientos post quirúrgicos. El costo es pagado directamente por Keenan & Associates, a través del programa de compensación de su empleador, de modo que usted nunca tendrá que ver una factura.

Si necesita tratamiento de emergencia vaya a la sala de emergencias más cercana, o llame al 911.

Keenan & Associates hará arreglos para el tratamiento médico con un especialista para la lesión correspondiente. Redes de proveedores preferenciales pueden ser utilizados por médicos como también centros de tratamiento médico.

Si usted tiene cobertura de seguro de salud, es elegible para recibir tratamiento con su médico personal o grupo médico si se lesiona en el trabajo. Si es elegible, deberá notificar a su empleador **por escrito antes de que cualquier lesión ocurra** , y deberá proporcionar a su empleador evidencia **por escrito** de su médico personal o grupo médico que indique que acepta esta designación anticipada. Su médico personal debe ser su médico de atención primaria regular que haya estado a cargo anteriormente de su tratamiento médico, y mantiene su historial y expedientes médicos. Solo puede predesignar a su médico de tratamiento primario si es un médico familiar, médico general, certificado o internista titulado, obstetra-ginecólogo o pediatra. Su médico personal puede ser un grupo médico multi-especial compuesto de médicos licenciados u osteópatas cuya práctica es predominantemente para lesiones y enfermedades no ocupacionales.

Es posible que su empleador use una Red de Proveedores Médicos (por sus siglas en inglés MPN), que es un grupo selecto de proveedores de asistencia médica seleccionados para dar tratamiento a los trabajadores lesionados en el trabajo. Si usted ha hecho una designación previa de un médico personal antes de lesionarse en el trabajo, entonces puede recibir tratamiento de su médico previamente designado. Si no ha hecho una designación previa y su empleador está usando una MPN, usted puede escoger un proveedor apropiado de la lista de la MPN después de la primera visita médica dirigida por su empleador o por Keenan & Associates.
Si está recibiendo tratamiento de parte de un médico que no pertenece a la MPN para una lesión existente, es posible que tenga que cambiar a un médico dentro de la MPN. Para más información, consulte la información de la Red de Proveedores Médicos en el reverso.

Si su empleador **no** participa en una Red de Proveedores Médicos, es posible que pueda cambiar su médico a su quiropráctico o acupunturista personal. Generalmente, su empleador o Keenan tienen el derecho a elegir al médico para su tratamiento durante los 30 días posteriores a la fecha en que su empleador supo de la lesión o enfermedad. Después de que su empleador o Keenan inicie su tratamiento, usted puede solicitar que dicho tratamiento sea transferido a su quiropráctico o acupunturista personal. Para que esto sea posible usted deberá notificar a su empleador, **por escrito, antes de la ocurrencia de cualquier lesión**. Sin embargo, un quiropráctico no puede ser su médico personal después de recibir 24 visitas quiroprácticas.

Su empleador le dará un formulario para que usted use como método optativo para predesignar a su médico personal.

Comuníquese con Keenan & Associates si piensa cambiar de médico en cualquier momento.

FEBRERO DE 2015

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Pago de ingresos perdidos – Si usted resulta temporalmente incapacitado debido a una lesión o enfermedad relacionada con el trabajo, recibirá ingresos libres de impuestos hasta que su médico indique que puede volver a trabajar. Los pagos serán dos terceras de su pago semanal normal, hasta un máximo establecido por la ley estatal. No se paga por los primeros tres días a no ser que usted sea internado en el hospital o no pueda trabajar por más de 14 días.

Si la lesión o enfermedad resulta en una incapacidad permanente, se le harán pagos adicionales después de recuperarse. Si la lesión resulta en su fallecimiento, se le pagarán los beneficios a sus dependientes sobrevivientes elegibles.

Rehabilitación – Para fechas de lesión del 01/01/04 y posteriores – Podría tener derecho a un ***Vale de desplazamiento de trabajo***, el cual le da derecho a un vale para recibir entrenamiento educativo.

Información de MPN

Harbor Health Systems MPN Contact
(888) 626-1737
MPNcontact@harborsys.com

Cómo obtener información adicional

Comuníquese con el representante de su empleador, o en caso de tener alguna pregunta acerca de sus beneficios de compensación a los trabajadores con Keenan & Associates. También puede comunicarse con un Funcionario de Información y Asistencia de la División Estatal de Compensación a los Trabajadores. Puede consultar con un abogado. La mayoría de los abogados ofrecen una primera consulta gratuita. Si desea contratar a un abogado, los honorarios serán deducidos de algunos de los beneficios que le correspondan. Para obtener los nombres de abogados de compensación a los trabajadores, llame al State Bar of California al teléfono 415-538-2120.

Oficinas de Información y Asistencia del Departamento de Compensación a los Trabajadores

Puede recibir información gratuita de un Funcionario de Información y Asistencia de la División de Compensación a los Trabajadores del estado. A continuación incluimos los números de teléfono. También puede escuchar información grabada llamando gratis al 800-736-7401 o visitando www.dwc.ca.gov.

Anaheim	714-414-1801
Bakersfield	661-395-2514
Eureka	707-441-5723
Fresno	559-445-5355
Goleta	805-968-4158
Long Beach	562-590-5001
Los Angeles	213-576-7389
Marina Del Rey	310-482-3858
Oakland	510-622-2861
Oxnard	805-485-3528
Pomona	909-623-8568
Redding	530-225-2047
Riverside	951-782-4347
Sacramento	916-928-3158
Salinas	831-443-3058
San Bernardino	909-383-4522
San Diego	619-767-2082
San Francisco	415-703-5020
San Jose	408-277-1292
San Luis Obispo	805-596-4159
Santa Ana	714-558-4597
Santa Rosa	707-576-2452
Stockton	209-948-7980
Van Nuys	818-901-5367

Oficinas de los ajustadores de Keenan & Associates

Torrance
800-654-8102

Eureka
707-268-1616

Pleasanton
925-225-0611

Rancho Cordova
800-343-0694

Redwood City
650-306-0616

Riverside
800-654-8347

San Jose
800-334-6554

Cualquier persona que con conocimiento, presenta o ayuda en la presentación de una demanda falsa de compensación laboral puede ser multada con una suma de hasta $150,000 y hasta 5 años en prisión.
[Código de seguros sección 1871.4]

Keenan
Associates

San Marcos Unified School District
255 Pico Ave.
San Marcos, CA
(760) 752-1299

INSTRUCTIONS FOR PREVENTING INJURIES AND RESPONDING TO INJURIES AT WORK

KEENAN SAFE SCHOOLS

Complete the recommended courses on **Keenan Safe Schools at https://sanmarcosusd-keenan.safeschools.com/login .** See the attached list for the occupation specific courses. Upon completion of your courses return the certificates of completion to Human Resources. Every employee is welcome to review and take any and all training courses available on the Keenan Safe Schools Platform.

INJURY & ILLNESS PREVENTION

Please review the District's Injury and Illness Prevention Plan (IIPP)located in the employee handbook. This can also be found on the District's website under Risk Management and at every school site front desk. It is important to the District that you are provided the training and tools needed to safely and skillfully do your job. You play a vital role in ensuring safe work practices to prevent injury and illness in the workplace.

REPORTING A WORKPLACE HAZARD:

If you would like to report a workplace hazard please contact Risk Management or refer to the Hazard Communication Plan with the District Injury & Illness Prevention Plan (IIPP).

IF YOU ARE INJURED AT WORK:

Report the injury or illness to your supervisor immediately. If you are unable to notify your supervisor please contact Risk Management. Your supervisor or Risk management will give you the following forms to complete:

- Employee's Workers' Compensation Packet – Instructions for Injured Workers

NEW HIRE PAMPHLET:

In the event of a work-related injury, this information includes important details regarding workers' compensation benefits.

IF YOU WOULD LIKE TO PRE-DESIGNATE YOUR OWN PHYSICIAN:

In the event of a work-related injury, you may elect to be treated by your own treating physician. You and your primary treating physician must fill out and complete the Pre-Designation Form (attached). This form must be on file with Human Resources & Risk Management prior to a work-related injury or illness for authorized treatment.

MEDICAL PROVIDER NETWORK:

Please review the attached Covered Employee Notification of Rights Materials. This information includes important details regarding the District's Medical Provider Network.

HANDS ON TRAINING:

You will be provided with hands-on training to learn how to work safely and accurately within your position.

SIGNATURE CONFIRMATION PAGE:

Please initial and sign where indicated on the attached Signature Confirmation Page which confirms you have received a copy of these instructions and all related materials have been provided to you.

**** "Workers' Compensation Fraud is a felony" -anyone who knowingly files or assists in the filing of a false workers' compensation claim may be fined up to $150,000 and imprisoned for up to five years (Insurance Code section 1871.4) *****

Signature Confirmation Page
San Marcos Unified School District

Please initial next to the following statements confirming your receipt of the New Employee Instructions and the related materials:

_____ I have received instructions for completing the recommended courses on the District's Keenan SafeSchools website. I further understand that all training in Keenan Safe Schools is available to me.0

_____ I have received and reviewed the District's Injury & Illness Prevention Plan to include the following program plans:

- Bloodborne Pathogens -Exposure Control Plan
- Heat Illness Prevention
- Hazard Communication Plan
- Fire Prevention Plan
- Lock Out/Tag Out Plan
- Medical waste Disposal Plan - Sharps & Pharmaceuticals

_____ I have received instructions for reporting a workplace hazard.

_____ I have received instructions for reporting a work-related injury or illness.

_____ I have received and reviewed the New Hire Pamphlet for work-related injury or illness.

_____ I have received instructions for pre-designating my treating physician for a work-related injury or illness.

Please print your name, sign, and date below.

_____
Employee Name (Please Print)

_____
Employee Signature

_____
Date

PRINT CLEAR

NOTICE OF PERSONAL CHIROPRACTOR OR PERSONAL ACUPUNCTURIST

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

NOTE: If your date of injury is January 1, 2004 or later, a chiropractor cannot be your treating physician after you have received 24 chiropractic visits unless your employer has authorized additional visits in writing. The term "chiropractic visit" means any chiropractic office visit, regardless of whether the services performed involve chiropractic manipulation or are limited to evaluation and management. Once you have received 24 chiropractic visits, if you still require medical treatment, you will have to select a new physician who is not a chiropractor. This prohibition shall not apply to visits for postsurgical physical medicine visits prescribed by the surgeon, or physician designated by the surgeon, under the postsurgical component of the Division of Workers' Compensation's Medical Treatment Utilization Schedule.

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

Your Chiropractor or Acupuncturist's Information:

_____

(name of chiropractor or acupuncturist)

_____

(street address, city, state, zip code)

_____

(telephone number)

_____

Employee Name **(please print)**:

_____

Employee's Address:

_____

Employee's Signature _____ Date: _____

Title 8, California Code of Regulations, section 9783.1.
(Optional DWC Form 9783.1 Effective date July 1, 2014)

San Marcos Unified School District Induction Program

Important Credential Information

Initial

- [ ] I understand that it is my responsibility to obtain, renew, and otherwise maintain a current Clear Credential. I will take all necessary steps to do so according to deadlines provided by the California Commission on Teacher Credentialing.

- [ ] I understand that my failure to maintain an active/current credential will result in my placement in an unpaid status, beginning on the date my credential expired. I understand this means I will not be paid for teaching services rendered while without a credential, and this status will provide grounds for non re-employment.

Preliminary Credential Holders Only

- [ ] I understand that completion of an approved CA Induction Program is required by CTC regulations for all candidates wanting to obtain a General Education Clear Credential and completion prior to the credential expiration date is a condition of employment.

- [ ] I understand that completion of an approved CA Clear Education Specialist Induction Program is required by CTC regulations for all candidates wanting to obtain an Education Specialist Clear Credential and completion prior to the credential expiration date is a condition of employment.

- [ ] I understand that it will be **MY** financial responsibility to pay for any services needed in order to complete the Induction program requirements.

Print Name _____ Signature _____ Date _____

SAN MARCOS UNIFIED SCHOOL DISTRICT
engaging students...inspiring futures

Human Resources and Development
255 Pico Avenue, Suite 250
San Marcos, CA 92069

T 760.752.1299
F 760.752.1138
www.smusd.org

Retirement System and Social Security System Disclosures

Please complete, sign and date

YES	NO	
☐	☐	Are you currently, or have you been, a member of CALPERS (California Public Employee Retirement System)?
☐	☐	Are you receiving a CALPERS pension payment?
☐	☐	Are you currently, or have you been, a member of CALSTRS (California State Teachers Retirement System)?
☐	☐	Are you receiving a CALSTRS pension payment?
☐	☐	Are you receiving Social Security Retirement benefits?

_____

Print Employee Name

_____ _____

Employee Signature Date

Permissive Membership-Instructions

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.

Permissive Membership-Instructions

SUBMITTING THE FORM

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. Submit the form by mail or the Secure Employer Website.

Mail to:	CalSTRS P.O. Box 15275, MS 17 Sacramento, CA 95851-0275
Secure Employer Website:	Attach the form to a secure message and submit via SEW

Please do not submit this form via email as it may contain personally identifiable information.

QUESTIONS

Employee – contact your employer

Employer – contact CalSTRS Employer Help

Permissive Membership

ES 0350 REV 03/20

[For CalSTRS' Official Use Only]

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

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.

ES0350

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).

EMPLOYEE SIGNATURE	DATE (MM/DD/YYYY)

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

POSITION TITLE	POSITION HIRE DATE

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).

EMPLOYER OFFICIAL'S SIGNATURE	DATE (MM/DD/YYYY)
EMPLOYER NAME San Marcos Unified School District	COUNTY AND DISTRICT CODE 37-73791
EMPLOYER OFFICIAL'S NAME AND TITLE Amber Christman: Human Resource Analyst	

Retirement System Election – Information and Instructions

CALSTRS

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 FORM:
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.

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

CalPERS
P.O. Box 942709 Sacramento, CA 94229-2709

CalSTRS also accepts the form by secure messaging via the Secure Employer Website.

Retirement System Election

ES 0372 REV 06/21

[For CalSTRS' Official Use Only]

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

RETIREMENT SYSTEM ELECTION AND ACKNOWLEDGEMENT OF RECEIPT OF RETIREMENT SYSTEM INFORMATION

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) *

ES0372

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	DATE

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.

EMPLOYEE POSITION INFORMATION:

POSITION HIRE DATE	POSITION EFFECTIVE DATE	POSITION TITLE

SELECT ONE: ☐ CREDENTIALED ☐ CLASSIFIED ☐ STATE SERVICE

EMPLOYER INFORMATION:

CO/DIST/STATE DEPT NAME		CALSTRS REPORT UNIT CODE
San Marcos Unified School District		
SCHOOL/STATE OFFICIAL'S NAME	TITLE	PHONE NUMBER
Amber Christman	HR Analyst	(760) 752-1244
SIGNATURE OF SCHOOL/STATE OFFICIAL		DATE
COUNTY OFFICIAL'S NAME	TITLE	PHONE NUMBER
SIGNATURE OF COUNTY OFFICIAL		*CALPERS EMPLOYER CODE

Recipient Designation

One-Time Death Benefit/Cash Balance Lump-Sum Payment

MS 0002 rev 01/20

CALSTRS®
California State Teachers' Retirement System
P.O. Box 15275, MS 43
Sacramento, CA 95851-0275
800-228-5453
CalSTRS.com

*** Your form will be rejected if any required field is left blank.**

This form is for designating recipients to receive the death benefits payable in the event of your death under the CalSTRS Defined Benefit Program and the Cash Balance Benefit Program. Print clearly in dark ink or type all information requested and initial any corrections. If you are not sure of your CalSTRS membership, see your most recent *Retirement Progress Report*, available on *my*CalSTRS, or call us at 800-228-5453. You may complete and submit this form online using your *my*CalSTRS account for faster processing. You'll receive step-by-step guidance to complete your form correctly, and your form will be submitted automatically.

Check one of the following:

☐ I am a member of the Defined Benefit Program. My recipient designation is for the one-time death benefit payable upon my death.

☐ I am a participant of the Cash Balance Benefit Program. My recipient designation is for the lump-sum payment to be distributed upon my death.

☐ I am a member/participant of both the Defined Benefit and Cash Balance programs. My recipient designation is for the death benefits payable under both programs. (Refer to instructions if recipients are different between programs.)

I hereby revoke any previous designations and designate the following primary recipients—that are living upon my death—to receive equal amounts, unless otherwise specified, as recipients of any benefits payable under the Teachers' Retirement Law at the time of my death. If any of my primary recipients predecease me, or waive or disclaim their interest, the percentage I designated to that recipient will be distributed proportionally to all my remaining primary recipients. If I survive the primary recipients, I designate the secondary recipients—that are living upon my death—to share equally, unless otherwise specified, as recipients for any benefits payable under law at the time of my death. If any of my secondary recipients predecease me, or waive or disclaim their interest, the percentage I designated to that recipient will be distributed proportionally to all my remaining secondary recipients. If I survive all of my named recipients, then any benefit payable at the time of my death will be paid to my estate. I understand this form does not designate a recipient to receive a continuing monthly retirement benefit.

Section 1: Member/Participant Information (*indicates required information)

NAME (LAST, FIRST, INITIAL)*

CLIENT ID OR SOCIAL SECURITY NUMBER*

MAILING ADDRESS*

DATE OF BIRTH (MM/DD/YYYY)*

CITY* **STATE*** **ZIP CODE***

( ) HOME TELEPHONE

EMAIL ADDRESS

Section 2: Primary Recipients (*indicates required information)

Use this area to designate one or more *primary* recipients to receive a death benefit.
Use additional sheets if needed.

FULL NAME OF PERSON, TRUST OR ORGANIZATION*

( ) TELEPHONE

MAILING ADDRESS*

CITY STATE ZIP CODE

☐ Person – Relationship: _____
Gender ☐ Male ☐ Female ☐ Nonbinary

☐ Organization – Contact Name: _____

☐ Trust

☐ Estate

SOCIAL SECURITY NUMBER/TAXPAYER ID NUMBER/EMPLOYER ID NUMBER*

DATE OF BIRTH/TRUST DATE (MM/DD/YYYY)*

PERCENTAGE*
(MUST TOTAL 100% FOR ALL PRIMARY RECIPIENTS)

MS0002

CALSTRS

*** Your form will be rejected if any required field is left blank.**

Section 2: Primary Recipients continued

FULL NAME OF PERSON, TRUST OR ORGANIZATION*

MAILING ADDRESS* ( ) TELEPHONE

CITY STATE ZIP CODE

☐ Person – Relationship: _____
Gender: ☐ Male ☐ Female ☐ Nonbinary

☐ Organization – Contact Name: _____

☐ Trust

☐ Estate

SOCIAL SECURITY NUMBER/TIN/EIN*

DATE OF BIRTH/TRUST DATE (MM/DD/YYYY)*

PERCENTAGE*
(MUST TOTAL 100% FOR ALL PRIMARY RECIPIENTS)*

FULL NAME OF PERSON, TRUST OR ORGANIZATION*

MAILING ADDRESS* ( ) TELEPHONE

CITY STATE ZIP CODE

☐ Person – Relationship: _____
Gender ☐ Male ☐ Female ☐ Nonbinary

☐ Organization – Contact Name: _____

☐ Trust

☐ Estate

SOCIAL SECURITY NUMBER/TIN/EIN*

DATE OF BIRTH/TRUST DATE (MM/DD/YYYY)*

PERCENTAGE*
(MUST TOTAL 100% FOR ALL PRIMARY RECIPIENTS)

Section 3: Secondary Recipients (*indicates required information)

Use this area to designate one or more *secondary* recipients to receive a death benefit should all of your primary recipients predecease you. Use additional sheets if needed.

FULL NAME OF PERSON, TRUST OR ORGANIZATION*

MAILING ADDRESS* ( ) TELEPHONE

CITY STATE ZIP CODE

☐ Person – Relationship: _____
Gender ☐ Male ☐ Female ☐ Nonbinary

☐ Organization – Contact Name: _____

☐ Trust

☐ Estate

SOCIAL SECURITY NUMBER/TIN/EIN*

DATE OF BIRTH/TRUST DATE (MM/DD/YYYY)*

PERCENTAGE*
(MUST TOTAL 100% FOR ALL SECONDARY RECIPIENTS)

MS0002

*** Your form will be rejected if any required field is left blank.**

Section 3: Secondary Recipients continued

FULL NAME OF PERSON, TRUST OR ORGANIZATION*

MAILING ADDRESS* ( ) TELEPHONE

CITY STATE ZIP CODE

☐ Person – Relationship: _____

Gender ☐ Male ☐ Female ☐ Nonbinary

☐ Organization – Contact Name: _____

☐ Trust

☐ Estate

SOCIAL SECURITY NUMBER/TIN/EIN*

DATE OF BIRTH/TRUST DATE (MM/DD/YYYY)*

PERCENTAGE *
(MUST TOTAL 100% FOR ALL SECONDARY RECIPIENTS)

☐ **Check this box if additional recipients are listed on an attachment. Identify each as *primary* or *secondary* and the percentages. Percentages must total 100% for all recipients. Important Note: All information marked with an asterisk is required. We will reject your form if any required field is left blank.**

Section 4: Required Signatures

Check all that apply.

☐ I am married or registered as a domestic partner and both our signatures are below.

☐ I am married or registered as a domestic partner and my spouse or partner did not sign below. I have completed and signed the *Justification for Non-Signature of Spouse or Registered Domestic Partner* section on the next page.

☐ I have never been married or in a registered domestic partnership, **or**
I am widowed or my partner has died.

☐ I have been divorced or terminated a registered domestic partnership and my former spouse or partner was awarded a portion of my CalSTRS benefits.

☐ I have been divorced or have terminated a registered domestic partnership and my former spouse or partner was *not* awarded a portion of my CalSTRS benefits.

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).

MEMBER'S SIGNATURE **SIGNATURE DATE (MM/DD/YYYY)**

SPOUSE'S OR REGISTERED DOMESTIC PARTNER'S SIGNATURE **SIGNATURE DATE (MM/DD/YYYY)**

SPOUSE'S OR PARTNER'S PRINTED NAME (LAST, FIRST, INITIAL)

SPOUSE'S OR PARTNER'S SOCIAL SECURITY NUMBER SPOUSE'S OR PARTNER'S DATE OF BIRTH (MM/DD/YYYY)

*** Your form will be rejected if any required field is left blank.**

Justification for Non-Signature of Spouse or Registered Domestic Partner

As required by Education Code sections 22453 and 26703, the signature of the spouse or registered domestic partner of the CalSTRS member or participant is required on any form in which the CalSTRS member or participant makes a request related to the election, change or cancellation of a CalSTRS benefit, subject to the following exceptions. If you are married or registered as a domestic partner and your spouse or partner did not sign one or more of the forms identified in the "Documents Submitted" section, you must check the appropriate box indicating the reason your spouse or partner did not sign.

- ☐ I do not know and have taken all reasonable steps to determine the whereabouts of my spouse or registered domestic partner.
- ☐ My spouse or registered domestic partner is incapable of executing the acknowledgment because of an incapacitating mental or physical condition.
- ☐ My current spouse or registered domestic partner has no identifiable community property interest in the benefits.
- ☐ My spouse or registered domestic partner and I have executed a settlement agreement that makes the community property law inapplicable to the marriage or registered domestic partnership.
- ☐ My spouse or registered domestic partner has refused to sign the acknowledgment. Court action will be or has been initiated to enforce or waive the signature requirement for my spouse or registered domestic partner (Education Code sections 22454 and 26704). CalSTRS must have a certified copy of the court order before any benefits can be paid. Submit a certified copy of the court order when you receive it.

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).

MEMBER'S SIGNATURE _____ **SIGNATURE DATE (MM/DD/YYYY)** _____

If you submit an incomplete form, we will not accept it. Be sure to review your form carefully before submitting it:

- ☐ Did you designate at least one primary recipient and provide all the required information?
- ☐ If you designated a trust, did you provide the name and date the trust was created? Do not provide your trust document at this time.
- ☐ If you designated percentages, do they equal 100 percent for your primary recipients and 100 percent for your secondary recipients?
- ☐ Did you sign and date the form?
- ☐ If you are married or in a registered domestic partnership, did your spouse or partner sign and date the form?
- ☐ If you cannot obtain your spouse or partner's signature, did you complete, sign and date the *Justification for Non-Signature of Spouse or Registered Domestic Partner?*

MS0002

DIRECT DEPOSIT AUTHORIZATION

PRINT or TYPE

NAME _____ EMPLOYEE ID NO._____

DISTRICT San Marcos Unified School District 37-73791 WORK SITE Amber Christman: Human Resource Analyst

Do you currently have an active Direct Deposit on file with another School District or Charter School within San Diego County? *Yes* ☐ *No* ☐

If yes, what District(s) and/or Charter School(s)? _____

I hereby authorize the above named School District(s), Charter School(s), and the San Diego County Office of Education (SDCOE) and/or their agents to initiate electronic deposits via the Automated Clearing House (ACH) and, as necessary, to debit corrections to previous deposits, to the account(s) specified below.

- Direct deposit status is not activated until my regular payroll cycle following a $0 test transaction (approx. 30 days).
- I must submit a new authorization form if I close/change my account (name, branch, etc.). Failure to do so may result in in a deposit delay.
- All new accounts must go through a Prenote verification (approx. 30 days), during which time a live warrant will be issued.
- Direct deposit status will be temporarily suspended if wages are garnished and/or the Credentials Unit at SDCOE places a hold on the warrant.
- It is my responsibility to keep apprised of any deposit(s) made to my account(s), including the date(s) and amount(s) of any such deposit(s).
- **I understand that I have only one direct deposit record for all active positions within a San Diego County School District, Charter School, or SDCOE, even if I am employed by more than one of these employers.**

I agree to hold harmless and indemnify the School District(s), Charter School(s), and SDCOE and their officers, employees, and agents from any claim or demand of whatever nature, including those based upon negligence of the District, School, or SDCOE and their officers, employees, and agents for failure or delay in making deposits and/or corrections to deposits as herein authorized.

This authorization replaces any previous agreements made by me and will remain in effect until changed or canceled by submission of a new Direct Deposit Authorization to the District, School, or SDCOE office in which I am currently employed. **All District, School, and SDCOE assignments, both current and future, will automatically be linked to the most recent Direct Deposit Authorization received by my current employer(s).**

Signature: _____ Date: _____

DEPOSIT INSTRUCTIONS: ☐ **New ACH Set Up (Prenote Needed)** ☐ **ACH Amount Change (No Prenote needed)** ☐ **ACH Cancellation**

Name of Financial institution _____

address of Financial institution _____

Financial institution t ransit r outing No. ☐☐☐☐☐☐☐☐☐

Checking

☐ Net Check, or

☐ $ _____

☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Checking Account Number

Savings

☐ Net Check, or

☐ $ _____

☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Savings a ccount Number

ATTACH VOIDED, BLANK CHECK HERE, IF DEPOSITING TO A CHECKING OR SHARE DRAFT ACCOUNT

Jane A. Doe
1000 Main St.
Anywhere, U.S.A. 10001

_____ 20____

PAy t o the
o r Der of _____ $_____

_____ Doll Ar S

Me Mo _____ _____

⑆122233344⑆ 999111222⑈ 1234

t ransit r outing No. Account No. Check No.

Form 224 - Bu S
SDCOE 1/15

Payroll/HR Use Only:
If applicable - Payroll/HR Department has notified other District and/or Charter School of Direct Deposit update on _____ Date ____Initials

Form **W-4**

Department of the Treasury
Internal Revenue Service

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.**

OMB No. 1545-0074

2022

Step 1: Enter Personal Information

(a) First name and middle initial	Last name	**(b) Social security number**
Address		► **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*.
City or town, state, and ZIP code		

(c) ☐ **Single** or **Married filing separately**
☐ **Married filing jointly** or **Qualifying widow(er)**
☐ **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.)

Complete Steps 2–4 ONLY if they apply to you; otherwise, skip to Step 5. See page 2 for more information on each step, who can claim exemption from withholding, when to use the estimator at *www.irs.gov/W4App*, and privacy.

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) Use the estimator at *www.irs.gov/W4App* for most accurate withholding for this step (and Steps 3–4); **or**

(b) Use the Multiple Jobs Worksheet on page 3 and enter the result in Step 4(c) below for roughly accurate withholding; **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 accurate for jobs with similar pay; otherwise, more tax than necessary may be withheld . . ► ☐

TIP: To be accurate, submit a 2022 Form W-4 for all other jobs. If you (or your spouse) have self-employment income, including as an independent contractor, use the estimator.

Complete Steps 3–4(b) on Form W-4 for only ONE of these jobs. Leave those steps blank for the other jobs. (Your withholding will be most accurate if you complete Steps 3–4(b) on the Form W-4 for the highest paying job.)

Step 3: Claim Dependents

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 and enter the total here . . . . . **3** $

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 . . . . . **4(a)** $

(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 . . . . . **4(b)** $

(c) Extra withholding. Enter any additional tax you want withheld each **pay period** . . **4(c)** $

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)

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 2022 if you meet both of the following conditions: you had no federal income tax liability in 2021 **and** you expect to have no federal income tax liability in 2022. You had no federal income tax liability in 2021 if (1) your total tax on line 24 on your 2021 Form 1040 or 1040-SR is zero (or less than the sum of lines 27a, 28, 29, and 30), 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 2022 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, 2023.

Your privacy. If you prefer to limit information provided in Steps 2 through 4, use the online estimator, which will also increase accuracy.

As an alternative to the estimator: 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). If this is the only job in your household, you may instead check the box in Step 2(c), which will increase your withholding and significantly reduce your paycheck (often by thousands of dollars over the year).

When to use the estimator. Consider using the estimator at *www.irs.gov/W4App* if you:

1. Expect to work only part of the year;

2. Have dividend or capital gain income, or are subject to additional taxes, such as Additional Medicare Tax;

3. Have self-employment income (see below); or

4. Prefer the most accurate withholding for multiple job situations.

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 these taxes through withholding from your wages, use the estimator at *www.irs.gov/W4App* to figure the amount to have withheld.

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.

Option **(a)** most accurately calculates the additional tax you need to have withheld, while option **(b)** does so with a little less accuracy.

If you (and your spouse) have a total of only two jobs, you may instead 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 2022 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.

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; or, you can use the online withholding estimator at *www.irs.gov/W4App*.

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 2022 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:
- $25,900 if you're married filing jointly or qualifying widow(er)
- $19,400 if you're head of household
- $12,950 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(f)(2) and 6109 and their regulations require you to provide this information; your employer uses it to determine your federal income tax withholding. Failure to provide a properly completed form will result in your being treated as a single person 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 possessions for use in administering their tax laws; and to the Department of Health and Human Services for use in the National Directory of New Hires. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

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

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

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

Married Filing Jointly or Qualifying Widow(er)

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	$0 - 9,999	$10,000 - 19,999	$20,000 - 29,999	$30,000 - 39,999	$40,000 - 49,999	$50,000 - 59,999	$60,000 - 69,999	$70,000 - 79,999	$80,000 - 89,999	$90,000 - 99,999	$100,000 - 109,999	$110,000 - 120,000
$0 - 9,999	$0	$110	$850	$860	$1,020	$1,020	$1,020	$1,020	$1,020	$1,020	$1,770	$1,870
$10,000 - 19,999	110	1,110	1,860	2,060	2,220	2,220	2,220	2,220	2,220	2,970	3,970	4,070
$20,000 - 29,999	850	1,860	2,800	3,000	3,160	3,160	3,160	3,160	3,910	4,910	5,910	6,010
$30,000 - 39,999	860	2,060	3,000	3,200	3,360	3,360	3,360	4,110	5,110	6,110	7,110	7,210
$40,000 - 49,999	1,020	2,220	3,160	3,360	3,520	3,520	4,270	5,270	6,270	7,270	8,270	8,370
$50,000 - 59,999	1,020	2,220	3,160	3,360	3,520	4,270	5,270	6,270	7,270	8,270	9,270	9,370
$60,000 - 69,999	1,020	2,220	3,160	3,360	4,270	5,270	6,270	7,270	8,270	9,270	10,270	10,370
$70,000 - 79,999	1,020	2,220	3,160	4,110	5,270	6,270	7,270	8,270	9,270	10,270	11,270	11,370
$80,000 - 99,999	1,020	2,820	4,760	5,960	7,120	8,120	9,120	10,120	11,120	12,120	13,150	13,450
$100,000 - 149,999	1,870	4,070	6,010	7,210	8,370	9,370	10,510	11,710	12,910	14,110	15,310	15,600
$150,000 - 239,999	2,040	4,440	6,580	7,980	9,340	10,540	11,740	12,940	14,140	15,340	16,540	16,830
$240,000 - 259,999	2,040	4,440	6,580	7,980	9,340	10,540	11,740	12,940	14,140	15,340	16,540	17,590
$260,000 - 279,999	2,040	4,440	6,580	7,980	9,340	10,540	11,740	12,940	14,140	16,100	18,100	19,190
$280,000 - 299,999	2,040	4,440	6,580	7,980	9,340	10,540	11,740	13,700	15,700	17,700	19,700	20,790
$300,000 - 319,999	2,040	4,440	6,580	7,980	9,340	11,300	13,300	15,300	17,300	19,300	21,300	22,390
$320,000 - 364,999	2,100	5,300	8,240	10,440	12,600	14,600	16,600	18,600	20,600	22,600	24,870	26,260
$365,000 - 524,999	2,970	6,470	9,710	12,210	14,670	16,970	19,270	21,570	23,870	26,170	28,470	29,870
$525,000 and over	3,140	6,840	10,280	12,980	15,640	18,140	20,640	23,140	25,640	28,140	30,640	32,240

Single or Married Filing Separately

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	$0 - 9,999	$10,000 - 19,999	$20,000 - 29,999	$30,000 - 39,999	$40,000 - 49,999	$50,000 - 59,999	$60,000 - 69,999	$70,000 - 79,999	$80,000 - 89,999	$90,000 - 99,999	$100,000 - 109,999	$110,000 - 120,000
$0 - 9,999	$400	$930	$1,020	$1,020	$1,250	$1,870	$1,870	$1,870	$1,870	$1,970	$2,040	$2,040
$10,000 - 19,999	930	1,570	1,660	1,890	2,890	3,510	3,510	3,510	3,610	3,810	3,880	3,880
$20,000 - 29,999	1,020	1,660	1,990	2,990	3,990	4,610	4,610	4,710	4,910	5,110	5,180	5,180
$30,000 - 39,999	1,020	1,890	2,990	3,990	4,990	5,610	5,710	5,910	6,110	6,310	6,380	6,380
$40,000 - 59,999	1,870	3,510	4,610	5,610	6,680	7,500	7,700	7,900	8,100	8,300	8,370	8,370
$60,000 - 79,999	1,870	3,510	4,680	5,880	7,080	7,900	8,100	8,300	8,500	8,700	8,970	9,770
$80,000 - 99,999	1,940	3,780	5,080	6,280	7,480	8,300	8,500	8,700	9,100	10,100	10,970	11,770
$100,000 - 124,999	2,040	3,880	5,180	6,380	7,580	8,400	9,140	10,140	11,140	12,140	13,040	14,140
$125,000 - 149,999	2,040	3,880	5,180	6,520	8,520	10,140	11,140	12,140	13,320	14,620	15,790	16,890
$150,000 - 174,999	2,040	4,420	6,520	8,520	10,520	12,170	13,470	14,770	16,070	17,370	18,540	19,640
$175,000 - 199,999	2,720	5,360	7,460	9,630	11,930	13,860	15,160	16,460	17,760	19,060	20,230	21,330
$200,000 - 249,999	2,970	5,920	8,310	10,610	12,910	14,840	16,140	17,440	18,740	20,040	21,210	22,310
$250,000 - 399,999	2,970	5,920	8,310	10,610	12,910	14,840	16,140	17,440	18,740	20,040	21,210	22,310
$400,000 - 449,999	2,970	5,920	8,310	10,610	12,910	14,840	16,140	17,440	18,740	20,040	21,210	22,470
$450,000 and over	3,140	6,290	8,880	11,380	13,880	16,010	17,510	19,010	20,510	22,010	23,380	24,680

Head of Household

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	$0 - 9,999	$10,000 - 19,999	$20,000 - 29,999	$30,000 - 39,999	$40,000 - 49,999	$50,000 - 59,999	$60,000 - 69,999	$70,000 - 79,999	$80,000 - 89,999	$90,000 - 99,999	$100,000 - 109,999	$110,000 - 120,000
$0 - 9,999	$0	$760	$910	$1,020	$1,020	$1,020	$1,190	$1,870	$1,870	$1,870	$2,040	$2,040
$10,000 - 19,999	760	1,820	2,110	2,220	2,220	2,390	3,390	4,070	4,070	4,240	4,440	4,440
$20,000 - 29,999	910	2,110	2,400	2,510	2,680	3,680	4,680	5,360	5,530	5,730	5,930	5,930
$30,000 - 39,999	1,020	2,220	2,510	2,790	3,790	4,790	5,790	6,640	6,840	7,040	7,240	7,240
$40,000 - 59,999	1,020	2,240	3,530	4,640	5,640	6,780	7,980	8,860	9,060	9,260	9,460	9,460
$60,000 - 79,999	1,870	4,070	5,360	6,610	7,810	9,010	10,210	11,090	11,290	11,490	11,690	12,170
$80,000 - 99,999	1,870	4,210	5,700	7,010	8,210	9,410	10,610	11,490	11,690	12,380	13,370	14,170
$100,000 - 124,999	2,040	4,440	5,930	7,240	8,440	9,640	10,860	12,540	13,540	14,540	15,540	16,480
$125,000 - 149,999	2,040	4,440	5,930	7,240	8,860	10,860	12,860	14,540	15,540	16,830	18,130	19,230
$150,000 - 174,999	2,040	4,460	6,750	8,860	10,860	12,860	15,000	16,980	18,280	19,580	20,880	21,980
$175,000 - 199,999	2,720	5,920	8,210	10,320	12,600	14,900	17,200	19,180	20,480	21,780	23,080	24,180
$200,000 - 449,999	2,970	6,470	9,060	11,480	13,780	16,080	18,380	20,360	21,660	22,960	24,250	25,360
$450,000 and over	3,140	6,840	9,630	12,250	14,750	17,250	19,750	21,930	23,430	24,930	26,420	27,730

Employment Development Department
State of California

Clear Form

Employees'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	
First, Middle, Last Name	Social Security Number
Address City, State, and ZIP Code	Filing Status ☐ Single or Married (with two or more incomes) ☐ Married (one income) ☐ Head of Household

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) _____
   - 1b. Number of allowances from the Estimated Deductions (Worksheet B, if applicable.) _____
   - 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)** _____

OR

Exemption from Withholding

3. I claim exemption from withholding for 2022, and I certify I meet both of the conditions for exemption. (Check box here) ☐

OR

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

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).

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.

Married But Not Living With Your Spouse: You may check the "Head of Household" marital status box if you meet all of the following tests:
(1) Your spouse will not live with you **at any time** during the year;
(2) You will furnish over half of the cost of maintaining a home for the entire year for yourself and your child or stepchild who qualifies as your dependent; **and**
(3) You will file a separate return for the year.

Head of Household: To qualify, you must be unmarried or legally separated from your spouse and pay more than 50% of the costs of maintaining a home for the **entire** year for yourself and your dependent(s) or other qualifying individuals. Cost of maintaining the home includes such items as rent, property insurance, property taxes, mortgage interest, repairs, utilities, and cost of food. It does not include the individual's personal expenses or any amount which represents value of services performed by a member of the household of the taxpayer.

Worksheet A — **Regular Withholding Allowances**

(A)	Allowance for yourself — enter 1	(A)
(B)	Allowance for your spouse (if not separately claimed by your spouse) — enter 1	(B)
(C)	Allowance for blindness — yourself — enter 1	(C)
(D)	Allowance for blindness — your spouse (if not separately claimed by your spouse) — enter 1	(D)
(E)	Allowance(s) for dependent(s) — do not include yourself or your spouse	(E)
(F)	Total — add lines (A) through (E) above and enter on line 1a of the DE 4	(F) 0

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		1.
2.	Enter $9,606 if married filing joint with two or more allowances, unmarried head of household, or qualifying widow(er) with dependent(s) or $4,803 if single or married filing separately, dual income married, or married with multiple employers	–	2.
3.	Subtract line 2 from line 1, enter difference	=	3.
4.	Enter an estimate of your adjustments to income (alimony payments, IRA deposits)	+	4.
5.	Add line 4 to line 3, enter sum	=	5.
6.	Enter an estimate of your nonwage income (dividends, interest income, alimony receipts)	–	6.
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	=	7.
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**.		8.
9.	If line 6 is greater than line 5; Enter amount from line 6 (nonwage income)		9.
10.	Enter amount from line 5 (deductions)		10.
11.	Subtract line 10 from line 9, enter difference. Then, complete Worksheet C.		11.

*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 2022.	1.
2.	Enter estimate of nonwage income (line 6 of Worksheet B).	2.
3.	Add line 1 and line 2. Enter sum.	3.
4.	Enter itemized deductions or standard deduction (line 1 or 2 of Worksheet B, whichever is largest).	4.
5.	Enter adjustments to income (line 4 of Worksheet B).	5.
6.	Add line 4 and line 5. Enter sum.	6.
7.	Subtract line 6 from line 3. Enter difference.	7.
8.	Figure your tax liability for the amount on line 7 by using the 2022 tax rate schedules below.	8.
9.	Enter personal exemptions (line F of Worksheet A x $141.90).	9.
10.	Subtract line 9 from line 8. Enter difference.	10.
11.	Enter any tax credits. (See FTB Form 540).	11.
12.	Subtract line 11 from line 10. Enter difference. This is your total tax liability.	12.
13.	Calculate the tax withheld and estimated to be withheld during 2022. 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 2022. 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 2022.	13.
14.	Subtract line 13 from line 12. Enter difference. If this is less than zero, you do not need to have additional taxes withheld.	14.
15.	Divide line 14 by the number of pay periods remaining in the year. Enter this figure on line 2 of the DE 4.	15.

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 2022 Only

Single Persons, Dual Income Married With Multiple Employers

IF THE TAXABLE INCOME IS		COMPUTED TAX IS		
OVER	BUT NOT OVER	OF AMOUNT OVER...		PLUS
$0	$9,325	1.100%	$0	$0.00
$9,325	$22,107	2.200%	$9,325	$102.58
$22,107	$34,892	4.400%	$22,107	$383.78
$34,892	$48,435	6.600%	$34,892	$946.32
$48,435	$61,214	8.800%	$48,435	$1,840.16
$61,214	$312,686	10.230%	$61,214	$2,964.71
$312,686	$375,221	11.330%	$312,686	$28,690.30
$375,221	$625,369	12.430%	$375,221	$35,775.52
$625,369	$1,000,000	13.530%	$625,369	$66,868.92
$1,000,000	and over	14.630%	$1,000,000	$117,556.49

Unmarried Head of Household

IF THE TAXABLE INCOME IS		COMPUTED TAX IS		
OVER	BUT NOT OVER	OF AMOUNT OVER...		PLUS
$0	$18,663	1.100%	$0	$0.00
$18,663	$44,217	2.200%	$18,663	$205.29
$44,217	$56,999	4.400%	$44,217	$767.48
$56,999	$70,542	6.600%	$56,999	$1,329.89
$70,542	$83,324	8.800%	$70,542	$2,223.73
$83,324	$425,251	10.230%	$83,324	$3,348.55
$425,251	$510,303	11.330%	$425,251	$38,327.68
$510,303	$850,503	12.430%	$510,303	$47,964.07
$850,503	$1,000,000	13.530%	$850,503	$90,250.93
$1,000,000	and over	14.630%	$1,000,000	$110,477.87

Married Persons

IF THE TAXABLE INCOME IS		COMPUTED TAX IS		
OVER	BUT NOT OVER	OF AMOUNT OVER...		PLUS
$0	$18,650	1.100%	$0	$0.00
$18,650	$44,214	2.200%	$18,650	$205.15
$44,214	$69,784	4.400%	$44,214	$767.56
$69,784	$96,870	6.600%	$69,784	$1,892.64
$96,870	$122,428	8.800%	$96,870	$3,680.32
$122,428	$625,372	10.230%	$122,428	$5,929.42
$625,372	$750,442	11.330%	$625,372	$57,380.59
$750,442	$1,000,000	12.430%	$750,442	$71,551.02
$1,000,000	$1,250,738	13.530%	$1,000,000	$102,571.08
$1,250,738	and over	14.630%	$1,250,738	$136,495.93

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.

California Teacher Induction Program-CTI
Nancy Danielson-SMUSD District Lead Coordinator

I am excited for the opportunity to work with you in the California Teacher Induction Program called CTI. This program is required to clear your Preliminary Teaching Credential to earn a Professional Clear Credential. You can clear ALL preliminary credentials with this two year program. In San Marcos, we work with San Diego County of Education-SDCOE- for their Induction Program. The program provides a SM teacher to be your Mentor Coach for the school year. There are assignments that require you to look at your teaching in a deeper way and to provide you with observation opportunities.You will have time to consult with colleagues and other teachers.

The cost to participate in the CTI program through SDCOE is $2,500 per year. This can be paid in up to 5 installments by January. This cost covers the Mentor Coach stipend of $1,500 and administrative costs from both SDCOE and SMUSD. Participation in our program is not required, but you must find a program to clear your credential within five years. The program is designed for the crucial first two years of your teaching career. The CTC can add any requirements to clear credentials during those five years, so it is best to complete Induction as soon as possible. The best part of going with this program in SMUSD is the Mentor Coach, who we will do our best to assign from your school and/or subject or grade area. Also, you can earn University Credits of up to 8 units per year for an additional nominal cost to move up the salary schedule. Please note that interns are not eligible for this program.

If you choose to participate in the program, you will have the following:
-4 hours per month (approx. one hour per week) of Mentor Coach time
-5 meetings throughout the school year
-4 module assignments
-District Lead coordinator to help as needed

If you know of a Mentor Coach who may be able to support you this year, you may recommend them. The District Lead coordinator will work with Site Administrators to assign Mentor Coaches.

If you wish to participate in the SMUSD CTI program, please provide the following information asap by emailing nancy.danielson@smusd.org
Full Name:
Site:
Grade Level and/or Content:
Years of prior teaching experience under contract?
Mentor Coach Recommendation?

SAN MARCOS UNIFIED SCHOOL DISTRICT
engaging students...inspiring futures

Human Resources and Development
255 Pico Avenue, Suite 250
San Marcos, CA 92069

T 760.752.1299
F 760.752.1138
www.smusd.org

Certificated Catastrophic Leave Bank (CLB)

Eligibility: If you wish to participate in the program you will need to donate 1 Sick Day during the Initial Donation Period of October 9th through November 30th by submitting the attached form. All sick leave donations are irrevocable and all donations to the Bank are general donations and cannot be assigned by you to any specific employee. Days in the Catastrophic Leave Bank shall accumulate from academic year to academic year.

**If you initially decline to participate you must complete a 20-day waiting period before becoming eligible to request a withdrawal from the Bank after becoming a member of the program.*

**New hires and employees returning from an extended leave of absence will be permitted to join the program within 30 calendar days of working for the District.*

SAN MARCOS
UNIFIED SCHOOL DISTRICT
engaging students...inspiring futures

Catastrophic Leave Bank Program
Certificated Voluntary Donation of Sick Leave

I, _____, hereby agree to donate 1 day of accumulated Sick Leave, in order to participate in the District's Catastrophic Leave Program.

I hereby agree that this donation is completely voluntary on my part and is unconditional and irrevocable. This donation is made pursuant to the terms of the SMUSD/SMEA Memorandum of Understanding dated May 1, 2020.

_____	_____	_____
Donator's Signature & Date	Employee I.D. #	Donator's Site