



HARTNELL COLLEGE

# INSTRUCTIONS FOR COMPLETING NON-CREDIT INSTRUCTOR PAPERWORK

Human Resources & Equal Employment Opportunity

Welcome to Hartnell College! This packet includes the forms necessary to process you as a new academic employee and therefore authorize you to begin service. You may not begin service until these forms are completed and returned to your **hiring department**. Please return all required forms in **one single submission**. The following should provide you with helpful information for completing your employment process.

## TASKS TO COMPLETE IMMEDIATELY UPON HIRE

### o **Fingerprint Requirements - Request for Live Scan Service** (Form BCII 8016):

The California Education Code requires that you be fingerprinted within 10 working days of employment. Hartnell contracts with the Monterey County Sheriff's Office at 1414 Natividad Road in Salinas to take and submit your fingerprints at no charge to you.

Call the Sheriff's Office at 755-3726 for an appointment (expect an approximate two week wait time). Bring your Request for Live Scan Service form with the applicant information section completed **and** a valid picture ID to your appointment. The Sheriff's Office will keep the original page of the form. Return the yellow copy immediately to your hiring department and retain the pink copy for your records.

**NOTE: You cannot begin employment without being cleared by HR.**

### o **TB Requirements - TB Skin Test Authorization** (Form HR-9):

The California Education Code requires that you provide proof that you are free of active tuberculosis through an examination performed within the past 60 days. If you are joining Hartnell directly from employment with another California educational institution where you had a TB test within the past four years, you may ask your former school to transfer your TB record to Hartnell.

WorkWell Health Services in Salinas has been contracted to administer your TB Skin Test or X-ray at Hartnell's expense. If you do not reside in Salinas, and/or your work schedule does not allow you an open window of opportunity to be tested by WorkWell, you may have your TB test performed by one of the alternative Doctors locations listed on the back of your TB Skin Test Authorization. Complete the information on the TB Skin Test Authorization form and be sure to refer to the back of the form for important information. Your TB Skin Test Authorization letter from the Human Resources Office must be presented at the time of testing or you will be charged for the testing.

Submit the results of your TB Test to your hiring department within 10 days of employment. Failure to submit your test results may result in withholding your paycheck or removal from your teaching assignment.

## FORMS FOR YOU TO COMPLETE AND RETURN

### o **Data Sheet for Non-Credit Instructors** (Form HR-43):

Complete top portion of this form and refer to the bottom for a list of all documents to be completed and returned. Return this sheet with your Employment Paperwork

### o **Employee's Withholding Allowance Certificate** (Form W-4):

Complete all sections on the Certification section (bottom portion); Do not leave box #5 blank! (Your original social security card reflecting your current name must be presented to your hiring department to be photocopied for payroll verification of your name and Social Security Number. Bring your card with you.)

### o **Employment Eligibility Verification** (Form I-9):

Within three (3) days of employment you must complete the I-9 form and present ORIGINAL copies of your verification documents to your hiring department for inspection and verification. On the I-9 Form, complete all of Section 1, ending with "Employee's Signature" and "Date". Choose the documents(s) you will show as verification of your eligibility to work in the U.S. (Review the list on the reverse side of the form—you may use either one item from list A only, or one item from list B and one from list C).

**Timesaving tip:** you already must present your social security card for W-4 purposes.

○ **Certificated Personnel Information Form (Form HR-24X):**

Complete "Part I" through "Part III" (the top box). Don't forget your signature at the bottom of "Part III."

○ **STRS Permissive Election and Acknowledgment of Receipt of CALSTRS Defined Benefit Plan Membership Information (Form ES 350):**

You are employed in a temporary position normally not subject to mandatory membership in the California State Teachers' Retirement System (STRS). You must elect or decline voluntary membership in the STRS retirement system by completing this form. If you elect STRS membership, your membership election is irrevocable for all future employment in a STRS covered position; If you do not elect STRS membership, the only optional retirement program currently available to you through this District is Social Security.

Read and complete all information in "Employee Certification" box (including electing or declining membership), sign and date form. Your signature also acknowledges that you have received information from us concerning the CalSTRS Defined Benefit Program (DB Program) and understand the criteria for membership in the plan. This information is available in the "Welcome to CalSTRS" publication provided to you and/or available at [http://www.calstrs.com/help/forms\\_publications/pubs.aspx](http://www.calstrs.com/help/forms_publications/pubs.aspx). This link also provides access to current "Member Handbook," as well as the "Join CalPERS? Join CalSTRS?" publication.

**PERS MEMBERS NOTE:** *If you are a PERS member, you must notify Human Resources. Failure to do so may negate your opportunity to elect to remain in PERS and continue contributing to the PERS retirement system. This election MUST be made in writing, within 60 days of hire. Please contact Human Resources to ensure you receive the mandatory election form and relevant information.*

○ **Statement Concerning Your Employment in a Job Not Covered by Social Security (Form SSA-1945):**

Read, sign and date. (Leave the Employee ID # blank)

○ **Physician Designation Form (Form HR-20):**

This is for work related accidents or illnesses. If you *DO NOT* designate a doctor you *must* go to a listed Medical Panel provider for your first 30 days of treatment. If you *DO* designate a doctor, you may go to that doctor for treatment without having to wait the 30 days. **Your name, social security number, signature and completion of the Emergency Information are required regardless of whether or not a doctor is designated.** An informational packet regarding work injuries entitled "The Basics of Workers' Compensation" is included in your packet.

○ **Warrant(s) Recipient Designation (Form HR-17):**

Fill in the blanks. You may also wish to amend the form so that it reads "... as the person who, after my death, **or incapacitation**, is entitled to receive..."

○ **Demographic Information (Form HR-36):**

Complete and submit. This form is for required reporting purposes only. It will be kept confidential and separate from all employment information.

○ **Automatic Deposit Authorization (Form HR-25X):**

This form is optional. You are responsible for contacting your bank for the exact information and format required by your bank. Currently our payroll system only allows automatic deposit to one account at one banking institution. If you choose this option, you will still receive a pay stub delineating your earnings and deductions.

○ **Retirement Questionnaire (Form HR-19):**

Answer each yes/no question and fill in the blanks as applicable. Sign the form.

**Hint:** If you previously taught in CA and worked 60 hours or more in one pay period, you most likely contributed to STRS.

○ **Standards of Employment/Service Agreement (Form HR-16):**

Read and initial all five paragraphs. A Drug Free Workplace pamphlet has been included in your packet for your reading. Your signature must be made in the presence of your department representative or Human Resources.

## **INFORMATION PROVIDED FOR YOU TO REVIEW**

Please read links provided on Hartnell's HR website

- **AP & BP 3720**
- **Basics of Workers' Compensation** - Referred to on 'Physician Designation Form'
- **Drug Free Workplace Brochure** - Referred to on 'Standards of Employment/Service Agreement' Form
- **Welcome to CalSTRS 2007-2008** - Referred to on 'STRS Permissive Election and Acknowledgment of Receipt of CALSTRS Defined Benefit Plan Membership Information' Form
- **Health Insurance Marketplace Coverage**



HARTNELL COLLEGE

## DATA SHEET FOR NON-CREDIT INSTRUCTOR

Human Resources & Equal Employment Opportunity

- ☐ Dr.  
☐ Mr.  
☐ Ms.

\_\_\_\_\_  
Last Name First Name MI

Address: \_\_\_\_\_

Street

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

Home Phone: \_\_\_\_\_ E-Mail Address: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Sex: ☐ Female ☐ Male

Semester you will be teaching: Fall 20 \_\_\_\_\_ Spring 20 \_\_\_\_\_ Summer 20 \_\_\_\_\_

### AREA

- |   |   |   |                                       |
|---|---|---|---------------------------------------|
| <input type="checkbox"/> Fine Arts/Social Science/Language Arts | <input type="checkbox"/> Physical Education     | <input type="checkbox"/> Student Services | <input type="checkbox"/> Counseling   |
| <input type="checkbox"/> Math/Science/AHT                       | <input type="checkbox"/> Occupational Education | <input type="checkbox"/> Library          | <input type="checkbox"/> Theatre Arts |
| <input type="checkbox"/> Nursing                                | <input type="checkbox"/> King City Center       | <input type="checkbox"/> ALC              |                                       |

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### RETURN WITH THE FOLLOWING FORMS - DEPARTMENT USE ONLY

- ☐ Fingerprints (Appointment Scheduled) \_\_\_\_/\_\_\_\_/\_\_\_\_ (or Taken) \_\_\_\_/\_\_\_\_/\_\_\_\_  
☐ Valid Negative TB Report (Appointment Scheduled) \_\_\_\_/\_\_\_\_/\_\_\_\_ (or Taken) \_\_\_\_/\_\_\_\_/\_\_\_\_  
☐ Demographic Information (*Form HR-36*)  
☐ Employee's Withholding Allowance Certificate (*Form W-4*)  
Must include a copy of Social Security Card  
☐ Employment Eligibility Verification (*Form I-9*)  
☐ Certificated Personnel Information Form (*Form HR-24X*)  
☐ Retirement Questionnaire (*Form HR-19*)  
☐ STRS Permissive Election and Acknowledgment of Receipt of CALSTRS Defined Benefit Plan  
Membership Information (*Form ES 350*)  
☐ Statement Concerning Your Employment in a Job Not Covered by Social Security (*Form SSA-1945*)  
☐ Physician Designation Form (*Form HR-20*)  
☐ Warrant(s) Recipient Designation (*Form HR-17*)  
☐ Standards of Employment/Service Agreement (*Form HR-16*)  
☐ Automatic Deposit Authorization (*Form HR-25X*)

Payroll \_\_\_\_/\_\_\_\_/\_\_\_\_

Access \_\_\_\_/\_\_\_\_/\_\_\_\_

MCOE \_\_\_\_/\_\_\_\_/\_\_\_\_

Datatel \_\_\_\_/\_\_\_\_/\_\_\_\_

# Form W-4 (2019)

**Future developments.** For the latest information about any future developments related to Form W-4, such as legislation enacted after it was published, go to [www.irs.gov/FormW4](http://www.irs.gov/FormW4).

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

**Exemption from withholding.** You may claim exemption from withholding for 2019 if **both** of the following apply.

- For 2018 you had a right to a refund of **all** federal income tax withheld because you had **no** tax liability, **and**
- For 2019 you expect a refund of **all** federal income tax withheld because you expect to have **no** tax liability.

If you're exempt, complete **only** lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2019 expires February 17, 2020. See Pub. 505, Tax Withholding and Estimated Tax, to learn more about whether you qualify for exemption from withholding.

## General Instructions

If you aren't exempt, follow the rest of these instructions to determine the number of withholding allowances you should claim for withholding for 2019 and any additional amount of tax to have withheld. For regular wages, withholding must be based on allowances you claimed and may not be a flat amount or percentage of wages.

You can also use the calculator at [www.irs.gov/W4App](http://www.irs.gov/W4App) to determine your tax withholding more accurately. Consider

using this calculator if you have a more complicated tax situation, such as if you have a working spouse, more than one job, or a large amount of nonwage income not subject to withholding outside of your job. After your Form W-4 takes effect, you can also use this calculator to see how the amount of tax you're having withheld compares to your projected total tax for 2019. If you use the calculator, you don't need to complete any of the worksheets for Form W-4.

Note that if you have too much tax withheld, you will receive a refund when you file your tax return. If you have too little tax withheld, you will owe tax when you file your tax return, and you might owe a penalty.

**Filers with multiple jobs or working spouses.** If you have more than one job at a time, or if you're married filing jointly and your spouse is also working, read all of the instructions including the instructions for the Two-Earners/Multiple Jobs Worksheet before beginning.

**Nonwage income.** If you have a large amount of nonwage income not subject to withholding, such as interest or dividends, consider making estimated tax payments using Form 1040-ES, Estimated Tax for Individuals. Otherwise, you might owe additional tax. Or, you can use the Deductions, Adjustments, and Additional Income Worksheet on page 3 or the calculator at [www.irs.gov/W4App](http://www.irs.gov/W4App) to make sure you have enough tax withheld from your paycheck. If you have pension or annuity income, see Pub. 505 or use the calculator at [www.irs.gov/W4App](http://www.irs.gov/W4App) to find out if you should adjust your withholding on Form W-4 or W-4P.

**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

### Personal Allowances Worksheet

Complete this worksheet on page 3 first to determine the number of withholding allowances to claim.

**Line C. Head of household please note:** Generally, you may claim head of household filing status on your tax return only if you're unmarried and pay more than 50% of the costs of keeping up a home for yourself and a qualifying individual. See Pub. 501 for more information about filing status.

**Line E. Child tax credit.** When you file your tax return, you may be eligible to claim a child tax credit for each of your eligible children. To qualify, the child must be under age 17 as of December 31, must be your dependent who lives with you for more than half the year, and must have a valid social security number. To learn more about this credit, see Pub. 972, Child Tax Credit. To reduce the tax withheld from your pay by taking this credit into account, follow the instructions on line E of the worksheet. On the worksheet you will be asked about your total income. For this purpose, total income includes all of your wages and other income, including income earned by a spouse if you are filing a joint return.

**Line F. Credit for other dependents.** When you file your tax return, you may be eligible to claim a credit for other dependents for whom a child tax credit can't be claimed, such as a qualifying child who doesn't meet the age or social security number requirement for the child tax credit, or a qualifying relative. To learn more about this credit, see Pub. 972. To reduce the tax withheld from your pay by taking this credit into account, follow the instructions on line F of the worksheet. On the worksheet, you will be asked about your total income. For this purpose, total

----- Separate here and give Form W-4 to your employer. Keep the worksheet(s) for your records. -----

<b>Form W-4</b> Department of the Treasury Internal Revenue Service		<b>Employee's Withholding Allowance Certificate</b>		OMB No. 1545-0074	
		▶ <b>Whether you're entitled to claim a certain number of allowances or exemption from withholding is subject to review by the IRS. Your employer may be required to send a copy of this form to the IRS.</b>		<b>2019</b>	
<b>1</b> Your first name and middle initial		Last name		<b>2</b> Your social security number	
Home address (number and street or rural route)		<b>3</b> <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Married, but withhold at higher Single rate. <b>Note:</b> If married filing separately, check "Married, but withhold at higher Single rate."			
City or town, state, and ZIP code		<b>4</b> If your last name differs from that shown on your social security card, check here. You must call 800-772-1213 for a replacement card. ▶ <input type="checkbox"/>			
<b>5</b> Total number of allowances you're claiming (from the applicable worksheet on the following pages) . . . . .		<b>5</b>			
<b>6</b> Additional amount, if any, you want withheld from each paycheck . . . . .		<b>6</b> \$			
<b>7</b> I claim exemption from withholding for 2019, and I certify that I meet <b>both</b> of the following conditions for exemption. • Last year I had a right to a refund of <b>all</b> federal income tax withheld because I had <b>no</b> tax liability, <b>and</b> • This year I expect a refund of <b>all</b> federal income tax withheld because I expect to have <b>no</b> tax liability. If you meet both conditions, write "Exempt" here . . . . . ▶ <b>7</b>					
Under penalties of perjury, I declare that I have examined this certificate and, to the best of my knowledge and belief, it is true, correct, and complete.					
<b>Employee's signature</b> (This form is not valid unless you sign it.) ▶					
<b>8</b> Employer's name and address ( <b>Employer:</b> Complete boxes 8 and 10 if sending to IRS and complete boxes 8, 9, and 10 if sending to State Directory of New Hires.)		<b>9</b> First date of employment		<b>10</b> Employer identification number (EIN)	

income includes all of your wages and other income, including income earned by a spouse if you are filing a joint return.

**Line G. Other credits.** You may be able to reduce the tax withheld from your paycheck if you expect to claim other tax credits, such as tax credits for education (see Pub. 970). If you do so, your paycheck will be larger, but the amount of any refund that you receive when you file your tax return will be smaller. Follow the instructions for Worksheet 1-6 in Pub. 505 if you want to reduce your withholding to take these credits into account. Enter “-0-” on lines E and F if you use Worksheet 1-6.

### **Deductions, Adjustments, and Additional Income Worksheet**

Complete this worksheet to determine if you're able to reduce the tax withheld from your paycheck to account for your itemized deductions and other adjustments to income, such as IRA contributions. If you do so, your refund at the end of the year will be smaller, but your paycheck will be larger. You're not required to complete this worksheet or reduce your withholding if you don't wish to do so.

You can also use this worksheet to figure out how much to increase the tax withheld from your paycheck if you have a large amount of nonwage income not subject to withholding, such as interest or dividends.

Another option is to take these items into account and make your withholding more accurate by using the calculator at [www.irs.gov/W4App](http://www.irs.gov/W4App). If you use the calculator, you don't need to complete any of the worksheets for Form W-4.

### **Two-Earners/Multiple Jobs Worksheet**

Complete this worksheet if you have more than one job at a time or are married filing jointly and have a working spouse. If you

don't complete this worksheet, you might have too little tax withheld. If so, you will owe tax when you file your tax return and might be subject to a penalty.

Figure the total number of allowances you're entitled to claim and any additional amount of tax to withhold on all jobs using worksheets from only one Form W-4. Claim all allowances on the W-4 that you or your spouse file for the highest paying job in your family and claim zero allowances on Forms W-4 filed for all other jobs. For example, if you earn \$60,000 per year and your spouse earns \$20,000, you should complete the worksheets to determine what to enter on lines 5 and 6 of your Form W-4, and your spouse should enter zero (“-0-”) on lines 5 and 6 of his or her Form W-4. See Pub. 505 for details.

Another option is to use the calculator at [www.irs.gov/W4App](http://www.irs.gov/W4App) to make your withholding more accurate.

**Tip:** If you have a working spouse and your incomes are similar, you can check the “Married, but withhold at higher Single rate” box instead of using this worksheet. If you choose this option, then each spouse should fill out the Personal Allowances Worksheet and check the “Married, but withhold at higher Single rate” box on Form W-4, but only one spouse should claim any allowances for credits or fill out the Deductions, Adjustments, and Additional Income Worksheet.

### **Instructions for Employer**

**Employees, do not complete box 8, 9, or 10. Your employer will complete these boxes if necessary.**

**New hire reporting.** Employers are required by law to report new employees to a designated State Directory of New Hires. Employers may use Form W-4, boxes 8, 9,

and 10 to comply with the new hire reporting requirement for a newly hired employee. A newly hired employee is an employee who hasn't previously been employed by the employer, or who was previously employed by the employer but has been separated from such prior employment for at least 60 consecutive days. Employers should contact the appropriate State Directory of New Hires to find out how to submit a copy of the completed Form W-4. For information and links to each designated State Directory of New Hires (including for U.S. territories), go to [www.acf.hhs.gov/css/employers](http://www.acf.hhs.gov/css/employers).

If an employer is sending a copy of Form W-4 to a designated State Directory of New Hires to comply with the new hire reporting requirement for a newly hired employee, complete boxes 8, 9, and 10 as follows.

**Box 8.** Enter the employer's name and address. If the employer is sending a copy of this form to a State Directory of New Hires, enter the address where child support agencies should send income withholding orders.

**Box 9.** If the employer is sending a copy of this form to a State Directory of New Hires, enter the employee's first date of employment, which is the date services for payment were first performed by the employee. If the employer rehired the employee after the employee had been separated from the employer's service for at least 60 days, enter the rehire date.

**Box 10.** Enter the employer's employer identification number (EIN).

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

<b>A</b>	Enter "1" for yourself . . . . .	<b>A</b>	_____
<b>B</b>	Enter "1" if you will file as married filing jointly . . . . .	<b>B</b>	_____
<b>C</b>	Enter "1" if you will file as head of household . . . . .	<b>C</b>	_____
<b>D</b>	Enter "1" if: <div style="display: inline-block; vertical-align: middle;"> <ul style="list-style-type: none"> <li>• You're single, or married filing separately, and have only one job; or</li> <li>• You're married filing jointly, have only one job, and your spouse doesn't work; or</li> <li>• Your wages from a second job or your spouse's wages (or the total of both) are \$1,500 or less.</li> </ul> </div>	<b>D</b>	_____
<b>E</b>	<b>Child tax credit.</b> See Pub. 972, Child Tax Credit, for more information. <ul style="list-style-type: none"> <li>• If your total income will be less than \$71,201 (\$103,351 if married filing jointly), enter "4" for each eligible child.</li> <li>• If your total income will be from \$71,201 to \$179,050 (\$103,351 to \$345,850 if married filing jointly), enter "2" for each eligible child.</li> <li>• If your total income will be from \$179,051 to \$200,000 (\$345,851 to \$400,000 if married filing jointly), enter "1" for each eligible child.</li> <li>• If your total income will be higher than \$200,000 (\$400,000 if married filing jointly), enter "-0-" . . . . .</li> </ul>		
<b>F</b>	<b>Credit for other dependents.</b> See Pub. 972, Child Tax Credit, for more information. <ul style="list-style-type: none"> <li>• If your total income will be less than \$71,201 (\$103,351 if married filing jointly), enter "1" for each eligible dependent.</li> <li>• If your total income will be from \$71,201 to \$179,050 (\$103,351 to \$345,850 if married filing jointly), enter "1" for every two dependents (for example, "-0-" for one dependent, "1" if you have two or three dependents, and "2" if you have four dependents).</li> <li>• If your total income will be higher than \$179,050 (\$345,850 if married filing jointly), enter "-0-" . . . . .</li> </ul>		
<b>G</b>	<b>Other credits.</b> If you have other credits, see Worksheet 1-6 of Pub. 505 and enter the amount from that worksheet here. If you use Worksheet 1-6, enter "-0-" on lines E and F . . . . .		
<b>H</b>	Add lines A through G and enter the total here . . . . .	<b>H</b>	_____

For accuracy,  
complete all  
worksheets  
that apply.

- If you plan to **itemize** or **claim adjustments to income** and want to reduce your withholding, or if you have a large amount of nonwage income not subject to withholding and want to increase your withholding, see the **Deductions, Adjustments, and Additional Income Worksheet** below.
- If you **have more than one job at a time** or are **married filing jointly and you and your spouse both work**, and the combined earnings from all jobs exceed \$53,000 (\$24,450 if married filing jointly), see the **Two-Earners/Multiple Jobs Worksheet** on page 4 to avoid having too little tax withheld.
- If **neither** of the above situations applies, **stop here** and enter the number from line H on line 5 of Form W-4 above.

**Deductions, Adjustments, and Additional Income Worksheet**

**Note:** 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.

<b>1</b>	Enter an estimate of your 2019 itemized deductions. These include qualifying home mortgage interest, charitable contributions, state and local taxes (up to \$10,000), and medical expenses in excess of 10% of your income. See Pub. 505 for details . . . . .	<b>1</b>	\$ _____
<b>2</b>	Enter: <div style="display: inline-block; vertical-align: middle;"> <div style="display: inline-block; vertical-align: middle;"> <ul style="list-style-type: none"> <li>\$24,400 if you're married filing jointly or qualifying widow(er)</li> <li>\$18,350 if you're head of household</li> <li>\$12,200 if you're single or married filing separately</li> </ul> </div> </div>	<b>2</b>	\$ _____
<b>3</b>	<b>Subtract</b> line 2 from line 1. If zero or less, enter "-0-" . . . . .	<b>3</b>	\$ _____
<b>4</b>	Enter an estimate of your 2019 adjustments to income, qualified business income deduction, and any additional standard deduction for age or blindness (see Pub. 505 for information about these items) . . . . .	<b>4</b>	\$ _____
<b>5</b>	<b>Add</b> lines 3 and 4 and enter the total . . . . .	<b>5</b>	\$ _____
<b>6</b>	Enter an estimate of your 2019 nonwage income not subject to withholding (such as dividends or interest) . . . . .	<b>6</b>	\$ _____
<b>7</b>	<b>Subtract</b> line 6 from line 5. If zero, enter "-0-". If less than zero, enter the amount in parentheses . . . . .	<b>7</b>	\$ _____
<b>8</b>	<b>Divide</b> the amount on line 7 by \$4,200 and enter the result here. If a negative amount, enter in parentheses. Drop any fraction . . . . .	<b>8</b>	_____
<b>9</b>	Enter the number from the <b>Personal Allowances Worksheet</b> , line H, above . . . . .	<b>9</b>	_____
<b>10</b>	<b>Add</b> lines 8 and 9 and enter the total here. If zero or less, enter "-0-". If you plan to use the <b>Two-Earners/Multiple Jobs Worksheet</b> , also enter this total on line 1 of that worksheet on page 4. Otherwise, <b>stop here</b> and enter this total on Form W-4, line 5, page 1 . . . . .	<b>10</b>	_____

**Two-Earners/Multiple Jobs Worksheet**

**Note:** Use this worksheet *only* if the instructions under line H from the **Personal Allowances Worksheet** direct you here.

- 1** Enter the number from the **Personal Allowances Worksheet**, line H, page 3 (or, if you used the **Deductions, Adjustments, and Additional Income Worksheet** on page 3, the number from line 10 of that worksheet) . . . . . **1** \_\_\_\_\_
  - 2** Find the number in **Table 1** below that applies to the **LOWEST** paying job and enter it here. **However**, if you're married filing jointly and wages from the highest paying job are \$75,000 or less and the combined wages for you and your spouse are \$107,000 or less, don't enter more than "3" . . . . . **2** \_\_\_\_\_
  - 3** If line 1 is **more than or equal to** line 2, subtract line 2 from line 1. Enter the result here (if zero, enter "-0-") and on Form W-4, line 5, page 1. **Do not** use the rest of this worksheet . . . . . **3** \_\_\_\_\_
- Note:** If line 1 is **less than** line 2, enter "-0-" on Form W-4, line 5, page 1. Complete lines 4 through 9 below to figure the additional withholding amount necessary to avoid a year-end tax bill.
- 4** Enter the number from line 2 of this worksheet . . . . . **4** \_\_\_\_\_
  - 5** Enter the number from line 1 of this worksheet . . . . . **5** \_\_\_\_\_
  - 6** **Subtract** line 5 from line 4 . . . . . **6** \_\_\_\_\_
  - 7** Find the amount in **Table 2** below that applies to the **HIGHEST** paying job and enter it here . . . . . **7** \$ \_\_\_\_\_
  - 8** **Multiply** line 7 by line 6 and enter the result here. This is the additional annual withholding needed . . . . . **8** \$ \_\_\_\_\_
  - 9** **Divide** line 8 by the number of pay periods remaining in 2019. For example, divide by 18 if you're paid every 2 weeks and you complete this form on a date in late April when there are 18 pay periods remaining in 2019. Enter the result here and on Form W-4, line 6, page 1. This is the additional amount to be withheld from each paycheck . . . . . **9** \$ \_\_\_\_\_

<b>Table 1</b>				<b>Table 2</b>			
<b>Married Filing Jointly</b>		<b>All Others</b>		<b>Married Filing Jointly</b>		<b>All Others</b>	
If wages from <b>LOWEST</b> paying job are—	Enter on line 2 above	If wages from <b>LOWEST</b> paying job are—	Enter on line 2 above	If wages from <b>HIGHEST</b> paying job are—	Enter on line 7 above	If wages from <b>HIGHEST</b> paying job are—	Enter on line 7 above
\$0 - \$5,000	0	\$0 - \$7,000	0	\$0 - \$24,900	\$420	\$0 - \$7,200	\$420
5,001 - 9,500	1	7,001 - 13,000	1	24,901 - 84,450	500	7,201 - 36,975	500
9,501 - 19,500	2	13,001 - 27,500	2	84,451 - 173,900	910	36,976 - 81,700	910
19,501 - 35,000	3	27,501 - 32,000	3	173,901 - 326,950	1,000	81,701 - 158,225	1,000
35,001 - 40,000	4	32,001 - 40,000	4	326,951 - 413,700	1,330	158,226 - 201,600	1,330
40,001 - 46,000	5	40,001 - 60,000	5	413,701 - 617,850	1,450	201,601 - 507,800	1,450
46,001 - 55,000	6	60,001 - 75,000	6	617,851 and over	1,540	507,801 and over	1,540
55,001 - 60,000	7	75,001 - 85,000	7				
60,001 - 70,000	8	85,001 - 95,000	8				
70,001 - 75,000	9	95,001 - 100,000	9				
75,001 - 85,000	10	100,001 - 110,000	10				
85,001 - 95,000	11	110,001 - 115,000	11				
95,001 - 125,000	12	115,001 - 125,000	12				
125,001 - 155,000	13	125,001 - 135,000	13				
155,001 - 165,000	14	135,001 - 145,000	14				
165,001 - 175,000	15	145,001 - 160,000	15				
175,001 - 180,000	16	160,001 - 180,000	16				
180,001 - 195,000	17	180,001 and over	17				
195,001 - 205,000	18						
205,001 and over	19						

**Privacy Act and Paperwork Reduction**

**Act Notice.** We ask for the information on this form to carry out the Internal Revenue laws of the United States. Internal Revenue Code sections 3402(f)(2) and 6109 and their regulations require you to provide this information; your employer uses it to determine your federal income tax withholding. Failure to provide a properly completed form will result in your being treated as a single person who claims no withholding allowances; providing fraudulent information may subject you to penalties. Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation; to

cities, states, the District of Columbia, and U.S. commonwealths and possessions for use in administering their tax laws; and to the Department of Health and Human Services for use in the National Directory of New Hires. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

You aren't required to provide the information requested on a form that's 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.



**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):

<input type="checkbox"/> 1. A citizen of the United States
<input type="checkbox"/> 2. A noncitizen national of the United States ( <i>See instructions</i> )
<input type="checkbox"/> 3. A lawful permanent resident (Alien Registration Number/USCIS Number): _____
<input type="checkbox"/> 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. ( <i>See instructions</i> )  <i>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.</i>  1. Alien Registration Number/USCIS Number: _____ <b>OR</b> 2. Form I-94 Admission Number: _____ <b>OR</b> 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



Employer Completes Next Page







**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.")

<b>Employee Info from Section 1</b>	Last Name (Family Name)	First Name (Given Name)	M.I.	Citizenship/Immigration Status
<b>List A</b> Identity and Employment Authorization	<b>OR</b>	<b>List B</b> Identity	<b>AND</b>	<b>List C</b> Employment Authorization
Document Title		Document Title		Document Title
Issuing Authority		Issuing Authority		Issuing Authority
Document Number		Document Number		Document Number
Expiration Date (if any)(mm/dd/yyyy)		Expiration Date (if any)(mm/dd/yyyy)		Expiration Date (if any)(mm/dd/yyyy)
Document Title		<div>Additional Information</div> <div>QR Code - Sections 2 &amp; 3 Do Not Write In This Space</div>		
Issuing Authority				
Document Number				
Expiration Date (if any)(mm/dd/yyyy)				
Document Title				
Issuing Authority				
Document Number				
Expiration Date (if any)(mm/dd/yyyy)				
Document Title				
Issuing Authority				

**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	
Last Name of Employer or Authorized Representative		First Name of Employer or Authorized Representative		Employer's Business or Organization Name	
Employer's Business or Organization Address (Street Number and Name)			City or Town	State	ZIP Code

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

<b>A. New Name (if applicable)</b>			<b>B. Date of Rehire (if applicable)</b>	
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.

<b>LIST A</b> <b>Documents that Establish Both Identity and Employment Authorization</b>	<b>OR</b>	<b>LIST B</b> <b>Documents that Establish Identity</b>	<b>AND</b> <b>LIST C</b> <b>Documents that Establish Employment Authorization</b>
<ol style="list-style-type: none"> <li>1. U.S. Passport or U.S. Passport Card</li> <li>2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)</li> <li>3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa</li> <li>4. Employment Authorization Document that contains a photograph (Form I-766)</li> <li>5. For a nonimmigrant alien authorized to work for a specific employer because of his or her status:               <ol style="list-style-type: none"> <li>a. Foreign passport; and</li> <li>b. Form I-94 or Form I-94A that has the following:                   <ol style="list-style-type: none"> <li>(1) The same name as the passport; and</li> <li>(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.</li> </ol> </li> </ol> </li> <li>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</li> </ol>		<ol style="list-style-type: none"> <li>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</li> <li>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</li> <li>3. School ID card with a photograph</li> <li>4. Voter's registration card</li> <li>5. U.S. Military card or draft record</li> <li>6. Military dependent's ID card</li> <li>7. U.S. Coast Guard Merchant Mariner Card</li> <li>8. Native American tribal document</li> <li>9. Driver's license issued by a Canadian government authority</li> <li>For persons under age 18 who are unable to present a document listed above:</li> <li>10. School record or report card</li> <li>11. Clinic, doctor, or hospital record</li> <li>12. Day-care or nursery school record</li> </ol>	<ol style="list-style-type: none"> <li>1. A Social Security Account Number card, unless the card includes one of the following restrictions:               <ol style="list-style-type: none"> <li>(1) NOT VALID FOR EMPLOYMENT</li> <li>(2) VALID FOR WORK ONLY WITH INS AUTHORIZATION</li> <li>(3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION</li> </ol> </li> <li>2. Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240)</li> <li>3. Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal</li> <li>4. Native American tribal document</li> <li>5. U.S. Citizen ID Card (Form I-197)</li> <li>6. Identification Card for Use of Resident Citizen in the United States (Form I-179)</li> <li>7. Employment authorization document issued by the Department of Homeland Security</li> </ol>

**Examples of many of these documents appear in Part 13 of the Handbook for Employers (M-274).**

**Refer to the instructions for more information about acceptable receipts.**



# CERTIFICATED PERSONNEL INFORMATION FORM

Monterey County Office of Education

## Certificated Employee to Complete

Social Security Number \_\_\_\_/\_\_\_\_/\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Gender \_\_\_\_

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ M.I. \_\_\_\_\_

Former Name (if applicable) \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_ Phone Number ( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_

Is this your first public teaching experience in California? ( ) Yes ( ) No

If no, year and County you last taught: Year \_\_\_\_\_ County \_\_\_\_\_

Have you previously taught in Monterey County? ( ) Yes ( ) No If yes, Year \_\_\_\_\_

Are you presently teaching in another school district? ( ) Yes ( ) No

If yes, District Name \_\_\_\_\_ Status: ( ) Full-time ( ) Part-time ( ) Substitute

Are you retired? ( ) Yes ( ) No If yes, name of district \_\_\_\_\_

If you are not teaching, where are you presently employed? \_\_\_\_\_

Are you a member of the State Teachers' Retirement System? ( ) Yes ( ) No

If no, did you ( ) Retire ( ) Refund Date \_\_\_\_\_

If a non-member, was the *Permissive Election and Acknowledgement* Form MR350 provided and explained to you? ( ) Yes ( ) No

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

## School District to Complete

District Name \_\_\_\_\_ First Date Worked in Position \_\_\_\_\_

Pay Frequency: ( ) 10 Mo. ( ) 11 Mo. ( ) 12 Mo. \_\_\_\_\_ % Contract

Non-Full-time Status: ( ) Substitute ( ) Home Teacher ( ) Part-Time ( ) Adult School

District REAP Verification: ( ) Not Available ( ) Status ( ) Not Found \_\_\_\_\_

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

## IMPORTANT DISTRIBUTION INSTRUCTIONS:

- Contracts and Election into Membership: Submit "blue" form with Election form to MCOE **immediately**.
- Substitutes who Do Not Elect: Submit "blue" form to MCOE the month substitute is **first paid**.

## MCOE to Complete

REAP Member Status \_\_\_\_\_ Date \_\_\_\_\_ Reap Status \_\_\_\_\_

MCOE STRS History \_\_\_\_\_

PRINT ON BLUE PAPER

## **IMPORTANT RETIREMENT ELECTION INFORMATION**

1. Has the *Permissive Election and Acknowledgement of Receipt of CalSTRS Defined Benefit Plan Membership Information*, Form ES350, been distributed to the employee if they are not a STRS member and don't mandatorily qualify? ( )Yes ( )No
  - a. When "I Elect Membership" is checked, set payroll retirement system to "Member", attach Form ES350 to blue form and submit to MCOE immediately.
  - b. When "I Decline Membership at This Time" is checked, file copy of Form ES350 in the employee's personnel file, and submit original blue form to MCOE in the first month that the employee is first paid.
2. Retirement Election Form ES372 – 60 day election window period. Give form to employee within 10 days.
  - a. When a STRS member accepts a qualifying CalPERS position, provide Form ES372.
  - b. When a PERS member accepts a qualifying CalSTRS position, provide Form ES372.
  - c. Provide Publication *Join CalSTRS? Join CalPERS*.

**District Signature**\_\_\_\_\_ **Date**\_\_\_\_\_



## Direct Deposit Enrollment Form

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
ID# or Last 4 of SSN

Below is a sample check MICR line, detailing where the information necessary to complete this form can be found.

Memo _____		
⑆ 0123456781 ⑆ 123456789 ⑆ 0101		
Routing/Transit # (A 9-digit number always between these two marks)	Checking Account #	Check # (this number matches the number in the upper right corner of the check – not needed for sign-up)

**You may have up to two active accounts at any time. Make sure to indicate what type of account, along with amount to be deposited if less than your total net pay.**

A C C T  1	<input type="checkbox"/> Add New Account <input type="checkbox"/> Change Amount of Current Account on File <input type="checkbox"/> Remove Account on File	
	Bank Name _____	
	Account Type <input type="checkbox"/> Checking <input type="checkbox"/> Savings	
	Routing/Transfer # _____	Account # _____
		Amount to Deposit \$ _____ or <input type="checkbox"/> Balance of Net

A C C T  2	<input type="checkbox"/> Add New Account <input type="checkbox"/> Change Amount of Current Account on File <input type="checkbox"/> Remove Account on File	
	Bank Name _____	
	Account Type <input type="checkbox"/> Checking <input type="checkbox"/> Savings	
	Routing/Transfer # _____	Account # _____
		Amount to Deposit \$ _____ or <input type="checkbox"/> Balance of Net

☐ I wish to terminate my enrollment in Direct Deposit. I understand that all future payroll payments to me will be in the form of a live check until I choose to enroll again in Direct Deposit.

Effective date of changes noted above (mm/dd/yy): \_\_\_\_\_

**I hereby authorize Hartnell College to deposit my pay in to the account(s) entered above.**

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

\_\_\_\_\_  
Date

For Payroll Use Only

Date Rec'd \_\_\_\_\_

Processed By \_\_\_\_\_

Date \_\_\_\_\_



HARTNELL COLLEGE

## workers' compensation: Pre-Designation of Personal Physician

If you have health insurance and 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 your pre-designated, 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. The 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 of 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 pre-designated.

If you do not provide advance written notification, verification, and agreement of your pre-designated personal physician, you will be treated by one of the District's designated workers' compensation medical providers.

**EMPLOYEE NAME:** \_\_\_\_\_ **LAST FOUR DIGITS OF SSN:** \_\_\_\_\_

- ☐ I acknowledge receipt of this form and do not elect to pre-designate 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: \_\_\_\_\_

- ☐ I elect to pre-designate that if I am injured on the job, I want 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.

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**\*A Personal Physician must be willing to be pre-designated to treat you for a workers' compensation injury.  
The remainder of this form is to be completed by your pre-designated 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 it, other written documentation of the physicians' agreement to be pre-designated 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.
- ☐ I do not agree to treat the above employee in the event of an industrial accident or injury.
- ☐ I do not qualify as the employees' personal physician, I am not an M.D. or D.O., or I do not meet the criteria outlined above.

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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

**Completed form must be returned to:  
Hartnell College, Human Resources Department  
Fax: 831.755.6937**

## 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 Program, you may use this form to elect membership at any time while employed to perform creditable service.

A permissive election of membership in the Defined Benefit Program is irrevocable and applies to all future creditable service performed for the same or another employer unless an election for coverage by the CalSTRS Cash Balance Benefit Program or California Public Employees' Retirement System (CalPERS) is made for eligible service as allowed by law.

Membership may only be cancelled if you terminate all employment to perform creditable service and refund your accumulated retirement contributions from the CalSTRS Defined Benefit Program.

### **SECTION 1: EMPLOYEE INFORMATION, ELECTION AND/OR CERTIFICATION (TO BE COMPLETED BY EMPLOYEE)**

Provide the following information:

- Last Name, First Name and Middle Initial
- CalSTRS Client ID or Social Security Number

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

If you want to elect membership in the CalSTRS Defined Benefit Program:

- Check the appropriate box
- Provide your requested membership date\*
- Sign the form and date your signature
- Return the form to your employer

\*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. Verify with your employer that you are eligible for your requested membership date.

If you do not want to elect membership in the Defined Benefit Program:

- Check the appropriate box
- Sign the form and date your signature
- Return the form to your employer

### **SECTION 2: EMPLOYER INFORMATION AND CERTIFICATION (TO BE COMPLETED BY EMPLOYER)**

Provide the following information:

- The employer (district) name
- County and district code
- Name and title of employer official completing the form

Verify the employee is eligible for the requested membership date.

Sign the form and date your signature.

Submit the form to CalSTRS and retain a copy.

### **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, fax or the Secure Employer Website and retain a copy.

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

Fax to: 916-414-5476

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 your CalSTRS Employer Services Representative.

# Permissive Membership

ES 0350 rev 01/19

# CALSTRS

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.

### Section 1: Employee Information, Election and/or Certification (to be completed by employee)

NAME (LAST, FIRST, INITIAL)

CALSTRS CLIENT ID OR SOCIAL SECURITY NUMBER

#### CHECK ONE:

- ☐ I elect membership in the CalSTRS Defined Benefit Program as of:

MEMBERSHIP DATE (MM/DD/YYYY)\*\*\*

I understand this election is irrevocable, 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 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.

- ☐ 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.

#### Required Signature

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 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'S SIGNATURE

SIGNATURE DATE (MM/DD/YYYY)

### Section 2: Employer Information and Certification (to be completed by employer)

Hartnell Community College District

Monterey 27024

EMPLOYER NAME

COUNTY AND DISTRICT CODE

EMPLOYER OFFICIAL'S NAME AND TITLE

#### 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

SIGNATURE DATE (MM/DD/YYYY)

\*\*\*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.

PERMISSIVE MEMBERSHIP • REV 01/19 • PAGE 1 OF 1



ES0350





HARTNELL COLLEGE

**WARRANT(S) RECIPIENT DESIGNATION / EMERGENCY CONTACT INFORMATION**

Human Resources & Equal Employment Opportunity

In the event of your death, salary or other monies may be owed to you as an employee of our district. The form below permits immediate release of any warrants (checks) to a person (18 years of age or older) you designate. This can often greatly assist in time of family stress or financial need. This form is available for your use on a voluntary basis.

As provided in §53245 of the California Government Code, in the event of my death, I hereby designate the following person (designee) to receive any and all warrants payable to me by the Hartnell Community College District.

Full Legal Name of DESIGNEE: \_\_\_\_\_

Relationship to Employee: \_\_\_\_\_

Home Address: \_\_\_\_\_

Phone number: \_\_\_\_\_ Email Address: \_\_\_\_\_

This designation form cancels and replaces any designation previously signed for this purpose and shall remain in effect until canceled in writing.

It is understood and agreed that the Hartnell Community College District is not obligated to deliver said warrant(s) to the person designated above unless the designated person, within two years after the date of said warrant(s) claims such warrant(s) from the Hartnell Community College District and provides sufficient proof of identity.

Employee Name: \_\_\_\_\_ Date: \_\_\_\_\_

Employee Signature: \_\_\_\_\_ S.S. #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

**GOVERNMENT CODE – STATE OF CALIFORNIA**

**§ 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 receives a warrant or check pursuant to this section is entitled to negotiate it as if he were the payee.

**EMERGENCY CONTACT INFORMATION (required):**

Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Phone #: \_\_\_\_\_

Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Phone #: \_\_\_\_\_



HARTNELL COLLEGE

## DEMOGRAPHIC INFORMATION (CONFIDENTIAL)

### Human Resources & Equal Employment Opportunity

The California Community College Chancellor's Office requires that we report summary data on all academic employees. This form will be kept confidential and separate from all employment information and will not be retained in your personnel file.

<b>Name:</b>																		
<b>Personal:</b>	<input type="checkbox"/> Female <input type="checkbox"/> Male																	
	Are you a person with a disability?* <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>*As defined in the Americans with Disabilities Act of 1990, a disabled person is one who:</b> (1) Has a physical or mental impairment which substantially limits one or more major life activities; (2) Has a record of such an impairment; or (3) Is regarded as having such impairment.																
	If yes, do you need any accommodation(s)? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes, please contact the Human Resources Office for services.</i>																	
<b>Heritage:</b>	<b>Are you Hispanic or Latino?</b> <input type="checkbox"/> Yes or <input type="checkbox"/> No  <input type="checkbox"/> Mexican, Mexican-American, Chicano <input type="checkbox"/> Central American <input type="checkbox"/> South American <input type="checkbox"/> Other Hispanic																	
	<b>What is your race / ethnicity? (Check one or more.)</b> <table border="0"><tr><td><input type="checkbox"/> Asian Indian</td><td><input type="checkbox"/> Chinese</td></tr><tr><td><input type="checkbox"/> Japanese</td><td><input type="checkbox"/> Korean</td></tr><tr><td><input type="checkbox"/> Laotian</td><td><input type="checkbox"/> Cambodian</td></tr><tr><td><input type="checkbox"/> Vietnamese</td><td><input type="checkbox"/> Filipino</td></tr><tr><td><input type="checkbox"/> Asian Other</td><td><input type="checkbox"/> Black or African American</td></tr><tr><td><input type="checkbox"/> American Indian / Alaskan Native</td><td><input type="checkbox"/> Guamanian</td></tr><tr><td><input type="checkbox"/> Hawaiian</td><td><input type="checkbox"/> Samoan</td></tr><tr><td><input type="checkbox"/> Pacific Islander Other</td><td><input type="checkbox"/> White</td></tr></table>		<input type="checkbox"/> Asian Indian	<input type="checkbox"/> Chinese	<input type="checkbox"/> Japanese	<input type="checkbox"/> Korean	<input type="checkbox"/> Laotian	<input type="checkbox"/> Cambodian	<input type="checkbox"/> Vietnamese	<input type="checkbox"/> Filipino	<input type="checkbox"/> Asian Other	<input type="checkbox"/> Black or African American	<input type="checkbox"/> American Indian / Alaskan Native	<input type="checkbox"/> Guamanian	<input type="checkbox"/> Hawaiian	<input type="checkbox"/> Samoan	<input type="checkbox"/> Pacific Islander Other	<input type="checkbox"/> White
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<input type="checkbox"/> American Indian / Alaskan Native	<input type="checkbox"/> Guamanian																	
<input type="checkbox"/> Hawaiian	<input type="checkbox"/> Samoan																	
<input type="checkbox"/> Pacific Islander Other	<input type="checkbox"/> White																	
<b>Veteran Status:</b>	<input type="checkbox"/> Veteran <input type="checkbox"/> Vietnam Veteran																	

## Statement Concerning Your Employment in a Job Not Covered by Social Security

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Employee Name	_____	Employee ID#	_____
Employer Name	Hartnell College	Employer ID#	77-0086025

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

### Windfall Elimination Provision

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

### Government Pension Offset Provision

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

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

### For More Information

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

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

Signature of Employee \_\_\_\_\_ Date \_\_\_\_\_

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

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

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

Employers must:

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

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

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



## RETIREMENT QUESTIONNAIRE

Human Resources & Equal Employment Opportunity

ALL non-student-personnel must complete this form and answer both STRS and PERS questions.

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

Employee Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

### STATE TEACHERS RETIREMENT SYSTEM (STRS) (academic/teaching retirement system)

Have you ever been a member of STRS? ☐ Yes ☐ No

If yes, have you received a refund? ☐ Yes ☐ No

If yes, date refunded: \_\_\_\_\_

If applicable, date retired: \_\_\_\_\_

### PUBLIC EMPLOYEES' RETIREMENT SYSTEM (PERS) (classified, non-teaching retirement system)

Have you ever been a member of PERS? ☐ Yes ☐ No

Have you acquired five years or more of Service Credit? ☐ Yes ☐ No

Have you only been in educational employment? ☐ Yes ☐ No

If yes to any of the above, have you received a refund? ☐ Yes ☐ No

If yes, date refunded: \_\_\_\_\_

If applicable, date retired: \_\_\_\_\_

Are you currently employed by any other District/Public Agency? ☐ Yes ☐ No

If yes, Name \_\_\_\_\_ ☐ Full time ☐ Part-time, time base \_\_\_\_\_

If yes, Name \_\_\_\_\_ ☐ Full time ☐ Part-time, time base \_\_\_\_\_

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

Date: \_\_\_\_\_

### IMPORTANT

**\*You are responsible for not exceeding your retirement system's post-retirement limit.**

**STRS** post-retirement earnings are limited to the fiscal year dollar amount established by STRS. If you are retired from STRS you may only work in an academic position.

**PERS** post-retirement work is limited to a calendar year maximum 960 hours of work. If you are retired from PERS you may work in a classified and/or academic position.

**STRS** mandatory membership qualification is met by working 60 hours in one pay period.

**PERS** mandatory membership qualification is met by working 1,000 hours in one fiscal year.

If you are a member of one retirement system and subsequently qualify for membership in the other system, you will have 60 days from qualification to elect to remain in one system or establish membership in both systems. More information is available at <http://www.calstrs.ca.gov/publications/pubs.htm>. Scroll down to *Member Benefit Information*, click on "Join CalSTRS? Or Join CalPERS? The Decision is Yours."



## STANDARDS OF EMPLOYMENT/SERVICE AGREEMENTS

Human Resources & Equal Employment Opportunity

I acknowledge my employment responsibilities with the Hartnell Community College District (HCCD) will bring me into contact with sensitive and confidential information. I understand that as a result of my access to the Colleague database and other HCCD resources, I am exposed to personal information about students, employees and other associates of HCCD. Such information may include, but may not be limited to their names, addresses, and contact information. I understand this information may be protected by privacy laws and is regarded as confidential by HCCD. My initials and signature below confirm my understanding that this information is protected by privacy laws and regarded as confidential by HCCD.

\_\_\_\_\_ Initial

My initials and signature below confirm my agreement to protect the personal privacy of employee, student and other individuals' records. I will prevent inappropriate or unnecessary disclosure of such records to unauthorized institutions, companies, groups, agencies, and individuals. I will collect and retain only such personal information as I may need to effectively conduct my duties for the District. I promise I will handle such information in a secure, confidential, and appropriate manner in accordance with relevant laws, regulations, policies and procedures. I understand that this agreement will be placed in my personnel file.

\_\_\_\_\_ Initial

HCCD is subject to the Federal Drug Free Workplace Act of 1998, in which HCCD is required to certify it will maintain a drug free workplace. As an employee of the District, my initials and signature below acknowledge that I am required to notify my supervisor, Human Resources, or the Superintendent/President of any conviction for a criminal drug statute violation occurring in the workplace within five days of such conviction. I am also required to read the HCCD Drug Free Workplace brochure. The Drug Free Workplace Act is also outlined in the Governing Board Policies. My initials and signature below acknowledges I have received, read, and understand the information in the brochure.

\_\_\_\_\_ Initial

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

\_\_\_\_\_ Initial

I acknowledge that I have received and read a copy of the Hartnell Community College District Board Policy 3720 and Administrative Procedure 3720, Computer and Network Use. I recognize and understand these rules and regulations. I agree to abide by the standards set in the policy and procedure for the duration of my employment. I am aware that violations of this computer and network use policy and procedure may subject me to disciplinary action including, but not limited to, revocation of my network account up to and including prosecution for violation of state and/or federal law.

\_\_\_\_\_ Initial

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

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

Date: \_\_\_\_\_

Taken and subscribed before me this \_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_.

Signature of Authorized HCCD Witness: \_\_\_\_