

MT. SAN ANTONIO COLLEGE

New Adjunct Hiring Checklist and Acknowledgement Form

Name: _____

Banner ID: A _____

Please review checklist to ensure all required paperwork is completed prior to submission to Human Resources.

Employee Submitted	Required Paperwork
<input type="checkbox"/>	Application for Employment (<i>Online applications must be included in packet</i>)
<input type="checkbox"/>	Personal Data Form
<input type="checkbox"/>	Withholding Forms – Federal & State
<input type="checkbox"/>	Employment Eligibility Verification–I-9 Form (<i>Instructions & list of acceptable documents on reverse side of I-9</i>)
<input type="checkbox"/>	Social Security card (<i>for IRS purposes</i>)
<input type="checkbox"/>	Oath of Allegiance
<input type="checkbox"/>	Warrant Designation
<input type="checkbox"/>	Hepatitis B Vaccination Program Form
<input type="checkbox"/>	Worker’s Compensation Pre-Designation Personal Physician Form
<input type="checkbox"/>	Tuberculosis Risk Assessment
<input type="checkbox"/>	Live Scan Confirmation (<i>employee obtains live scan form from HR</i>)
<input type="checkbox"/>	Eligibility for Employment Form (AB 1725 Minimum Qualifications OR AB 1725 Equivalencies)
Adjunct Retirement Plans:	
<input type="checkbox"/>	CalSTRS Permissive Election Form (REQUIRED FORM)
<input type="checkbox"/>	SSA-1945 (REQUIRED IF EMPLOYEE ELECTS STRS MEMBERSHIP)
Optional Paperwork:	
<input type="checkbox"/>	Direct Deposit Authorization Form (<i>attach voided check</i>)
<input type="checkbox"/>	CTA Membership Enrollment Form (<i>forward directly to Faculty Association Office</i>)
Informational Paperwork:	
<input type="checkbox"/>	New Health Insurance Marketplace Coverage (ACA)

Employee Acknowledgement: Copies of all forms are available on the HR website at:

- Asbestos Notification and Acknowledgement
- FMLA Information and Acknowledgement
- Non-Discrimination Statement and Acknowledgement
- District Policy on Drug Free Environment and Acknowledgement
- Reasonable Accommodation Information and Acknowledgement
- Sexual Harassment Brochure and Acknowledgement
- Use of Technology and Information Resources and Employee Acceptable Use Agreement (AP 3720) Acknowledgement
- Emergency Response Quick Reference Guide
- Disaster Service Workers Brochure
- Worker’s Compensation Information
- FMLA, PDL, and CFRA Information
- Notice of Social Security Alternative Plan – National Benefit Services (NBS) ***If CalSTRS membership is declined***

By signing this document, I hereby acknowledge that I have read, understand and agree to all requirements, policies and memos regarding my Adjunct position. Signature of this document also recognizes that all paperwork has been completed truthfully and to the best of my ability.

Employee Signature: _____

Date: _____

Employer Signature (Witness): _____

Date: _____



MT. SAN ANTONIO COLLEGE

Office of Human Resources
1100 N. Grand Avenue, Walnut, CA 91789
(909) 274-4225 Fax: (909) 274-2031
<http://jobs.mtsac.edu>

ADJUNCT FACULTY Application for Employment

Position applying for

A separate application must be provided for each position you are applying for.

Please print clearly or type all information requested.

Name	Last	First	Middle	Date
Address	Number	Street	Apt/Unit	Home Phone
	City	State	Zip Code	Work Phone
Email Address				Cellular Phone

EMPLOYMENT HISTORY: Please include all employment experience, listing the most recent position first. Provide complete employment history even if a résumé is attached. If there is more than one position with the same employer, list each position separately. If additional space is needed, use the same format on another piece of paper.

Dates	Duties	Employers
From To	Title	Employer
Hours/week	Responsibilities	Supervisor
<input type="checkbox"/> Full-time <input type="checkbox"/> Part-time		Address
Salary		City, State, Zip
May we contact? <input type="checkbox"/> Yes <input type="checkbox"/> No	Reason for leaving	Telephone
From To	Title	Employer
Hours/week	Responsibilities	Supervisor
<input type="checkbox"/> Full-time <input type="checkbox"/> Part-time		Address
Salary		City, State, Zip
May we contact? <input type="checkbox"/> Yes <input type="checkbox"/> No	Reason for leaving	Telephone
From To	Title	Employer
Hours/week	Responsibilities	Supervisor
<input type="checkbox"/> Full-time <input type="checkbox"/> Part-time		Address
Salary		City, State, Zip
May we contact? <input type="checkbox"/> Yes <input type="checkbox"/> No	Reason for leaving	Telephone

From To Title Employer
 Hours/week Responsibilities Supervisor
 Full-time Address
 Part-time Salary City, State, Zip

May we contact? Reason for leaving Telephone
 Yes No

From To Title Employer
 Hours/week Responsibilities Supervisor
 Full-time Address
 Part-time Salary City, State, Zip

May we contact? Reason for leaving Telephone
 Yes No

Will you accept part-time or temporary work? Yes No
 Will you work evening hours? Yes No
 If employed, can you submit verification of your legal right to work in the United States? Yes No

REFERENCES: Please list at least three current references that are familiar with your work-related ability and back round. Do not include relatives.

Name Position Company
 Address City State _____ Zip _____
 Day Time Phone Evening Phone E-mail

Name Position Company
 Address City State _____ Zip _____
 Day Time Phone Evening Phone E-mail

Name Position Company
 Address City State _____ Zip _____
 Day Time Phone Evening Phone E-mail

APPLICANT RELEASE

I authorize agents of Mt. San Antonio College (Mt. SAC) to investigate and verify all statements made on this application to include contacting my previous employers and references provided by me. I further authorize my previous and current employers, as well as all educational institutions that I attended, personal references, and public or private agencies that have issued me either a professional or vocational license to release to Mt. SAC, any and all records and other information maintained in their custody and control and which regard any all aspects of my employment relationship, history and educational background with said employers, educational institutions, personal references and public or private agencies. I understand and acknowledge that this authorization may permit positive as well as negative information to be released to Mt. SAC from individuals listed as references herein and the agents or employees of my former employers to answer any inquiry relevant to my application, and I hereby release the foregoing individuals from liability for responding to such inquires.

Applicants Signature

Date

EDUCATION

Check highest grade completed: 8 9 10 11 12 13 14 15 16 Graduate

High School _____ Location (City & State) _____ Did you graduate? Yes No If no, do you possess a G.E.D.? Yes No

Names and locations of accredited institutions	Major(s)	Minor(s)	Units earned	Degree conferred	Degree in progress	Date anticipated

Have you worked or attended postsecondary institutions under name(s) other than stated above?

Yes No If yes, please list: _____

Have you ever worked for Mt. San Antonio College? Yes No If yes, when: _____

Note: A "Yes" answer on the following question does not automatically disqualify you from receiving consideration for employment:

Have you ever been dismissed from employment or resigned in lieu of being dismissed for inefficiency, delinquency or misconduct? Yes No If yes, please explain: _____

VOCATIONAL, TECHNICAL or Other Training

Names and locations of Business or Trade Schools attended	Dates Attended	Subject	Degree/Certification

Professional Licenses/Certificates and expiration dates:

Professional Organizations to which you currently belong and are job-related:

CREDENTIALS: List all valid California Community College credentials held

Type	Subject Matter Area	Expiration Date

NARRATIVE: Please **ATTACH** a brief statement discussing the kinds of contributions you plan to make as a faculty member at Mt. San Antonio College. Also include specific qualifications that enable you to work with culturally diverse individuals, minority groups, and multi-ethnic programs.

EQUIVALENCY:

Are you applying for equivalency to the state minimum qualifications for this position? Yes No
If yes, please complete the supplemental form for Equivalency Determination.

TEACHING EXPERIENCE: Please list courses in your order of preference.

Qualified to Teach	Have Taught	Prefer to Teach

I certify that the information contained in this application is correct to the best of my knowledge and understand that deliberate falsification or any misstatements or omissions of material facts may be cause for refusal of employment; or if employed, cause for dismissal.

If employed, I understand that I will be required to submit verification of my identification and authorization to work in the United States, and that additional information about me will be required for statistical purposes.

Signature (Application is considered incomplete without a signature)

Date

All job offers made by the College are subject to Board of Trustees approval and are contingent upon the prospective employee establishing proof of identify and legal right to work in the United States as required by the Immigration and Naturalization Services. Recommended candidate for this position will be required to obtain fingerprint clearance prior beginning employment. An official notification or an x-ray report stating that you are free from tuberculosis is required before employment can begin (Education Code 87408.6). Prospective employees may be required to complete a satisfactory medical examination. Employment, or continued employment, is contingent upon a satisfactory health report.

It is the policy of Mt. San Antonio College that harassment is prohibited and that all persons shall receive equal employment and educational opportunities without regard to sex, race, color, ancestry, religious creed, national origin, age (over 40), medical condition (cancer), mental disability, physical disability (including HIV & AIDS), marital status, sexual orientation, or Vietnam Era Veteran Status. This nondiscrimination policy covers Family and Medical Care Leave and Pregnancy Disability Leave. Contact the Office of Human Resources if you need any special accommodations to complete the application process at (909) 594-5611, ext. 4225.

Mt. San Antonio College is an Equal Opportunity Employer

MT. SAN ANTONIO COLLEGE PERSONAL DATA FORM

Legal Name As Shown on Social Security Card (Last, First, Middle)			Preferred First Name (Optional):		
Home Address			Cellular Phone No.:		
City	State	Zip Code	Day Phone No.:		
Marital Status: <input type="checkbox"/> Unmarried <input type="checkbox"/> Married <input type="checkbox"/> Head of Household <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Domestic Partner <input type="checkbox"/> Widowed			Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Not Available		
Please select all that apply: I AM A <u>RETIREE</u> OF: <input type="checkbox"/> STRS; <input type="checkbox"/> PERS; <input type="checkbox"/> NONE I AM A <u>MEMBER</u> OF: <input type="checkbox"/> STRS; <input type="checkbox"/> PERS; <input type="checkbox"/> NONE			Campus-Wide Emergency Notifications Opt-in Cell: Home: Text:		

EMERGENCY CONTACT INFORMATION

Primary Emergency Contact Name (Last, First, M.I.):	Day Phone No.:	Relationship:
Secondary Emergency Contact Name (Last, First, M.I.):	Day Phone No.:	Relationship:

HUMAN RESOURCES USE ONLY			
<input type="checkbox"/> New Hire <input type="checkbox"/> Rehire	Office (OC):	Extension:	Department (Org) #:
Hire Date:	Salary/Board Date		
Employee Class: <input type="checkbox"/> 1 Adjunct <input type="checkbox"/> 4 Confidential <input type="checkbox"/> 2 Classified A <input type="checkbox"/> 5 Faculty <input type="checkbox"/> 3 Classified B <input type="checkbox"/> 6 Management	Minimum Qualifications		
	Discipline	Units of File	
Contract/Term:			
Step Increase Eligibility Date:	Longevity Eligibility Date:		
T.B. Assessment Date:	Livescan Clearance:		
Position Title:	Banner Position No:		
<input type="checkbox"/> *CalPERS <input type="checkbox"/> Classic <input type="checkbox"/> New <input type="checkbox"/> Unknown	Banner ID:		
<input type="checkbox"/> CalSTRS <input type="checkbox"/> SSA-1945 <input type="checkbox"/> National Benefit Services (NBS)			

*CalPERS membership (Classic or New) is ultimately determined by CalPERS; this is based on general information received from myCalPERS.ca.gov and inquiry from employee at the time of hire.

Banner Payroll

Processed by: _____

Ext: _____

Date: _____

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.**

2020

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) <input type="checkbox"/> Single or Married filing separately <input type="checkbox"/> Married filing jointly (or Qualifying widow(er)) <input type="checkbox"/> 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 online estimator, 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 2020 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 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)
	Mt. San Antonio College 1100 N. Grand Ave Walnut, CA 91789		

General Instructions

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.

Exemption from withholding. You may claim exemption from withholding for 2020 if you meet both of the following conditions: you had no federal income tax liability in 2019 and you expect to have no federal income tax liability in 2020. You had no federal income tax liability in 2019 if (1) your total tax on line 16 on your 2019 Form 1040 or 1040-SR is zero (or less than the sum of lines 18a, 18b, and 18c), 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 2020 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 1a, 1b, and 5. Do not complete any other steps. You will need to submit a new Form W-4 by February 16, 2021.

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 the 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. Step 3 of Form W-4 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. 972, Child Tax Credit and Credit for Other Dependents. You can also include **other tax credits** in this step, such as education tax credits and the foreign tax credit. 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 2020 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 2020 itemized deductions (from Schedule A (Form 1040 or 1040-SR)). Such deductions may 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 **1** \$ _____

- 2 Enter: $\left\{ \begin{array}{l} \bullet \$24,800 \text{ if you're married filing jointly or qualifying widow(er)} \\ \bullet \$18,650 \text{ if you're head of household} \\ \bullet \$12,400 \text{ if you're single or married filing separately} \end{array} \right\}$ **2** \$ _____

- 3 If line 1 is greater than line 2, subtract line 2 from line 1. 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 Schedule 1 (Form 1040 or 1040-SR)). 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	\$220	\$850	\$900	\$1,020	\$1,020	\$1,020	\$1,020	\$1,020	\$1,210	\$1,870	\$1,870
\$10,000 - 19,999	220	1,220	1,900	2,100	2,220	2,220	2,220	2,220	2,410	3,410	4,070	4,070
\$20,000 - 29,999	850	1,900	2,730	2,930	3,050	3,050	3,050	3,240	4,240	5,240	5,900	5,900
\$30,000 - 39,999	900	2,100	2,930	3,130	3,250	3,250	3,440	4,440	5,440	6,440	7,100	7,100
\$40,000 - 49,999	1,020	2,220	3,050	3,250	3,370	3,570	4,570	5,570	6,570	7,570	8,220	8,220
\$50,000 - 59,999	1,020	2,220	3,050	3,250	3,570	4,570	5,570	6,570	7,570	8,570	9,220	9,220
\$60,000 - 69,999	1,020	2,220	3,050	3,440	4,570	5,570	6,570	7,570	8,570	9,570	10,220	10,220
\$70,000 - 79,999	1,020	2,220	3,240	4,440	5,570	6,570	7,570	8,570	9,570	10,570	11,220	11,240
\$80,000 - 99,999	1,060	3,260	5,090	6,290	7,420	8,420	9,420	10,420	11,420	12,420	13,260	13,460
\$100,000 - 149,999	1,870	4,070	5,900	7,100	8,220	9,320	10,520	11,720	12,920	14,120	14,980	15,180
\$150,000 - 239,999	2,040	4,440	6,470	7,870	9,190	10,390	11,590	12,790	13,990	15,190	16,050	16,250
\$240,000 - 259,999	2,040	4,440	6,470	7,870	9,190	10,390	11,590	12,790	13,990	15,520	17,170	18,170
\$260,000 - 279,999	2,040	4,440	6,470	7,870	9,190	10,390	11,590	13,120	15,120	17,120	18,770	19,770
\$280,000 - 299,999	2,040	4,440	6,470	7,870	9,190	10,720	12,720	14,720	16,720	18,720	20,370	21,370
\$300,000 - 319,999	2,040	4,440	6,470	8,200	10,320	12,320	14,320	16,320	18,320	20,320	21,970	22,970
\$320,000 - 364,999	2,720	5,920	8,750	10,950	13,070	15,070	17,070	19,070	21,290	23,590	25,540	26,840
\$365,000 - 524,999	2,970	6,470	9,600	12,100	14,530	16,830	19,130	21,430	23,730	26,030	27,980	29,280
\$525,000 and over	3,140	6,840	10,170	12,870	15,500	18,000	20,500	23,000	25,500	28,000	30,150	31,650

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	\$460	\$940	\$1,020	\$1,020	\$1,470	\$1,870	\$1,870	\$1,870	\$1,870	\$2,040	\$2,040	\$2,040
\$10,000 - 19,999	940	1,530	1,610	2,060	3,060	3,460	3,460	3,460	3,640	3,830	3,830	3,830
\$20,000 - 29,999	1,020	1,610	2,130	3,130	4,130	4,540	4,540	4,720	4,920	5,110	5,110	5,110
\$30,000 - 39,999	1,020	2,060	3,130	4,130	5,130	5,540	5,720	5,920	6,120	6,310	6,310	6,310
\$40,000 - 59,999	1,870	3,460	4,540	5,540	6,690	7,290	7,490	7,690	7,890	8,080	8,080	8,080
\$60,000 - 79,999	1,870	3,460	4,690	5,890	7,090	7,690	7,890	8,090	8,290	8,480	9,260	10,060
\$80,000 - 99,999	2,020	3,810	5,090	6,290	7,490	8,090	8,290	8,490	9,470	10,460	11,260	12,060
\$100,000 - 124,999	2,040	3,830	5,110	6,310	7,510	8,430	9,430	10,430	11,430	12,420	13,520	14,620
\$125,000 - 149,999	2,040	3,830	5,110	7,030	9,030	10,430	11,430	12,580	13,880	15,170	16,270	17,370
\$150,000 - 174,999	2,360	4,950	7,030	9,030	11,030	12,730	14,030	15,330	16,630	17,920	19,020	20,120
\$175,000 - 199,999	2,720	5,310	7,540	9,840	12,140	13,840	15,140	16,440	17,740	19,030	20,130	21,230
\$200,000 - 249,999	2,970	5,860	8,240	10,540	12,840	14,540	15,840	17,140	18,440	19,730	20,830	21,930
\$250,000 - 399,999	2,970	5,860	8,240	10,540	12,840	14,540	15,840	17,140	18,440	19,730	20,830	21,930
\$400,000 - 449,999	2,970	5,860	8,240	10,540	12,840	14,540	15,840	17,140	18,450	19,940	21,240	22,540
\$450,000 and over	3,140	6,230	8,810	11,310	13,810	15,710	17,210	18,710	20,210	21,700	23,000	24,300

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	\$830	\$930	\$1,020	\$1,020	\$1,020	\$1,480	\$1,870	\$1,870	\$1,930	\$2,040	\$2,040
\$10,000 - 19,999	830	1,920	2,130	2,220	2,220	2,680	3,680	4,070	4,130	4,330	4,440	4,440
\$20,000 - 29,999	930	2,130	2,350	2,430	2,900	3,900	4,900	5,340	5,540	5,740	5,850	5,850
\$30,000 - 39,999	1,020	2,220	2,430	2,980	3,980	4,980	6,040	6,630	6,830	7,030	7,140	7,140
\$40,000 - 59,999	1,020	2,530	3,750	4,830	5,860	7,060	8,260	8,850	9,050	9,250	9,360	9,360
\$60,000 - 79,999	1,870	4,070	5,310	6,600	7,800	9,000	10,200	10,780	10,980	11,180	11,580	12,380
\$80,000 - 99,999	1,900	4,300	5,710	7,000	8,200	9,400	10,600	11,180	11,670	12,670	13,580	14,380
\$100,000 - 124,999	2,040	4,440	5,850	7,140	8,340	9,540	11,360	12,750	13,750	14,750	15,770	16,870
\$125,000 - 149,999	2,040	4,440	5,850	7,360	9,360	11,360	13,360	14,750	16,010	17,310	18,520	19,620
\$150,000 - 174,999	2,040	5,060	7,280	9,360	11,360	13,480	15,780	17,460	18,760	20,060	21,270	22,370
\$175,000 - 199,999	2,720	5,920	8,130	10,480	12,780	15,080	17,380	19,070	20,370	21,670	22,880	23,980
\$200,000 - 249,999	2,970	6,470	8,990	11,370	13,670	15,970	18,270	19,960	21,260	22,560	23,770	24,870
\$250,000 - 349,999	2,970	6,470	8,990	11,370	13,670	15,970	18,270	19,960	21,260	22,560	23,770	24,870
\$350,000 - 449,999	2,970	6,470	8,990	11,370	13,670	15,970	18,270	19,960	21,260	22,560	23,900	25,200
\$450,000 and over	3,140	6,840	9,560	12,140	14,640	17,140	19,640	21,530	23,030	24,530	25,940	27,240

EMPLOYEE'S WITHHOLDING ALLOWANCE CERTIFICATE

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

Enter Personal Information	
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. Total Number of Allowances you're claiming (Use Worksheet A for regular withholding allowances. Use other worksheets on the following pages as applicable, Worksheet A+B).
2. Additional amount, if any, you want withheld each pay period (if employer agrees), **(Worksheet B and C)**
OR

Exemption from Withholding

3. I claim exemption from withholding for 2020, and I certify I meet both of the conditions for exemption.
OR Write "Exempt" here
4. I certify under penalty of perjury that I am **not subject** to California withholding. I meet the conditions set forth under the Service Member Civil Relief Act, as amended by the Military Spouses Residency Relief Act. (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 Mt. San Antonio College 1100 N. Grand Ave Walnut, CA 91789	California Employer Payroll Tax Account Number
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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 Personal Income Tax (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 amended by the Military Spouses Residency Relief Act, you may be exempt from California income tax on your wages if

- (i) your spouse is a member of the armed forces present in California in compliance with military orders;
- (ii) you are present in California solely to be with your spouse; and
- (iii) you maintain your domicile in another state.

If you claim exemption under **this** act, **check the box on Line 4**. You may be required to provide proof of exemption upon request.

The [California Employer's Guide \(DE 44\) \(PDF, 2.4 MB\)](http://edd.ca.gov/pdf_pub_ctr/de44.pdf) (edd.ca.gov/pdf_pub_ctr/de44.pdf) provides the income tax withholding tables. This publication may be found by visiting [Forms and Publications](http://edd.ca.gov/Payroll_Taxes/Forms_and_Publications) (edd.ca.gov/Payroll_Taxes/Forms_and_Publications). To assist you in calculating your tax liability, please visit the [Franchise Tax Board \(FTB\)](http://ftb.ca.gov) (ftb.ca.gov).

If you need information on your last California Resident Income Tax Return (FTB Form 540), visit the [Franchise Tax Board \(FTB\)](http://ftb.ca.gov) (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 \(CCR\)](#), 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](#) and section 19176 of the [Revenue and Taxation Code](#).

WORKSHEETS

INSTRUCTIONS — 1 — ALLOWANCES*

When determining your withholding allowances, you must consider your personal situation:

- Do you claim allowances for dependents or blindness?
- Will you itemize your deductions?
- Do you have more than one income coming into the household?

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

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

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 1 of the DE 4 | (F) |

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 \$9,074 if married filing joint with two or more allowances, unmarried head of household, or qualifying widow(er) with dependent(s) or \$4,537 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
Add this number to Line F of Worksheet A and enter it on line 1 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 | 11. |

Complete Worksheet C

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

1. Enter estimate of total wages for tax year 2020. 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 2020 tax rate schedules below. 8.
9. Enter personal exemptions (line F of Worksheet A x \$134.20). 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 2020. 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 2020. 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 2020. 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 2020 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	\$8,809	1.100%	\$0	\$0.00
\$8,809	\$20,883	2.200%	\$8,809	\$96.90
\$20,883	\$32,960	4.400%	\$20,883	\$362.53
\$32,960	\$45,753	6.600%	\$32,960	\$893.92
\$45,753	\$57,824	8.800%	\$45,753	\$1,738.26
\$57,824	\$295,373	10.230%	\$57,824	\$2,800.51
\$295,373	\$354,445	11.330%	\$295,373	\$27,101.77
\$354,445	\$590,742	12.430%	\$354,445	\$33,794.63
\$590,742	\$1,000,000	13.530%	\$590,742	\$63,166.35
\$1,000,000	and over	14.630%	\$1,000,000	\$118,538.96

MARRIED PERSONS

IF THE TAXABLE INCOME IS		COMPUTED TAX IS		
OVER	BUT NOT OVER	OF AMOUNT OVER...		PLUS
\$0	\$17,618	1.100%	\$0	\$0.00
\$17,618	\$41,766	2.200%	\$17,618	\$193.80
\$41,766	\$65,920	4.400%	\$41,766	\$725.06
\$65,920	\$91,506	6.600%	\$65,920	\$1,787.84
\$91,506	\$115,648	8.800%	\$91,506	\$3,476.52
\$115,648	\$590,746	10.230%	\$115,648	\$5,601.02
\$590,746	\$708,890	11.330%	\$590,746	\$54,203.55
\$708,890	\$1,000,000	12.430%	\$708,890	\$67,589.27
\$1,000,000	\$1,181,484	13.530%	\$1,000,000	\$103,774.24
\$1,181,484	and over	14.630%	\$1,181,484	\$128,329.03

UNMARRIED HEAD OF HOUSEHOLD

IF THE TAXABLE INCOME IS		COMPUTED TAX IS		
OVER	BUT NOT OVER	OF AMOUNT OVER...		PLUS
\$0	\$17,629	1.100%	\$0	\$0.00
\$17,629	\$41,768	2.200%	\$17,629	\$193.92
\$41,768	\$53,843	4.400%	\$41,768	\$724.98
\$53,843	\$66,636	6.600%	\$53,843	\$1,256.28
\$66,636	\$78,710	8.800%	\$66,636	\$2,100.62
\$78,710	\$401,705	10.230%	\$78,710	\$3,163.13
\$401,705	\$482,047	11.330%	\$401,705	\$36,205.52
\$482,047	\$803,410	12.430%	\$482,047	\$45,308.27
\$803,410	\$1,000,000	13.530%	\$803,410	\$85,253.69
\$1,000,000	and over	14.630%	\$1,000,000	\$111,852.32

If you need information on your last California Resident Income Tax Return, FTB Form 540, visit [Franchise Tax Board \(FTB\)](http://ftb.ca.gov) (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.



Employment Eligibility Verification
Department of Homeland Security
 U.S. Citizenship and Immigration Services

USCIS
Form I-9
 OMB No. 1615-0047
 Expires 10/31/2022

▶ **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 <i>(Family Name)</i>		First Name <i>(Given Name)</i>		Middle Initial	Other Last Names Used <i>(if any)</i>	
Address <i>(Street Number and Name)</i>			Apt. Number	City or Town		State ZIP Code
Date of Birth <i>(mm/dd/yyyy)</i>	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>	
<p><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></p> <p>1. Alien Registration Number/USCIS Number: _____ OR 2. Form I-94 Admission Number: _____ OR 3. Foreign Passport Number: _____ Country of Issuance: _____</p>	
QR Code - Section 1 Do Not Write In This Space	

Signature of Employee	Today's Date <i>(mm/dd/yyyy)</i>
-----------------------	----------------------------------

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 <i>(mm/dd/yyyy)</i>	
Last Name <i>(Family Name)</i>		First Name <i>(Given Name)</i>	
Address <i>(Street Number and Name)</i>		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 10/31/2022

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		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		Additional Information		QR Code - Sections 2 & 3 Do Not Write In This Space
Issuing Authority				
Document Number				
Expiration Date (if any) (mm/dd/yyyy)				
Document Title				
Issuing Authority				
Document Number				
Expiration Date (if any) (mm/dd/yyyy)				

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 Mt. San Antonio College	
Employer's Business or Organization Address (Street Number and Name) 1100 N. Grand Avenue		City or Town Walnut	State CA	ZIP Code 91789

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
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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
<ol style="list-style-type: none"> 1. U.S. Passport or U.S. Passport Card 2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551) 3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa 4. Employment Authorization Document that contains a photograph (Form I-766) 5. For a nonimmigrant alien authorized to work for a specific employer because of his or her status: <ol style="list-style-type: none"> a. Foreign passport; and b. Form I-94 or Form I-94A that has the following: <ol style="list-style-type: none"> (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. 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 		<ol style="list-style-type: none"> 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 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 3. School ID card with a photograph 4. Voter's registration card 5. U.S. Military card or draft record 6. Military dependent's ID card 7. U.S. Coast Guard Merchant Mariner Card 8. Native American tribal document 9. Driver's license issued by a Canadian government authority <li style="text-align: center;">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 		<ol style="list-style-type: none"> 1. A Social Security Account Number card, unless the card includes one of the following restrictions: <ol style="list-style-type: none"> (1) NOT VALID FOR EMPLOYMENT (2) VALID FOR WORK ONLY WITH INS AUTHORIZATION (3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION 2. Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240) 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 4. Native American tribal document 5. U.S. Citizen ID Card (Form I-197) 6. Identification Card for Use of Resident Citizen in the United States (Form I-179) 7. Employment authorization document issued by the Department of Homeland Security

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

Refer to the instructions for more information about acceptable receipts.



HUMAN RESOURCES

OATH OF ALLEGIANCE

(Required by Government Code)

"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."

Signature of Employee

THE OATHS ABOVE SUBSCRIBED AND AFFIRMED TO BEFORE ME ON THIS
_____ DAY OF _____, 20_____.

WITNESS NAME: _____

WITNESS TITLE: _____



HUMAN RESOURCES

LAST PAY WARRANT (Check)

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 you designate. This can often greatly assist in time of family stress or financial need. Please complete the form and return it to the district Office of Human Resources.

WARRANT RECIPIENT DESIGNATION

(Please Print or Type)

As provided in Section 53245 of the California Government Code in the event of my death, I hereby designate _____ (designee) to receive any and all warrants payable to me.

Name of DESIGNEE: _____ Relationship: _____

Address: _____ City: _____ State: _____ Zip: _____

Telephone: _____

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

It is understood and agreed that the school district/agency is not obligated to deliver said warrants to the designee unless the designated person claims such warrants from the school district and provides sufficient proof of identity. A person so designated may negotiate the warrant(s) as if the payee.

School District/Agency: _____ Mt. San Antonio College

EMPLOYEE: _____ Date: _____

SIGNATURE: _____

HOW IS THE VACCINE ADMINISTERED?

The vaccination process consists of three separate injections into the upper arm. The injections are administered over a six-month period according to the following schedule:

First dose: On elected date (i.e., September 1);
Second dose: One month later (i.e., October 1);
Third dose: Six months after the first dose (i.e., March 1)

The Mt. San Antonio College District requires that employees opting for the vaccination sign consent form and that those employees who decline to accept the Hepatitis B vaccination sign a declaration statement. Please indicate your intentions by checking the appropriate response below:

- No My assignment does not require occupational exposure to blood or body fluids.
- No I have been vaccinated and/or have had Hepatitis B.
- No I have been informed of the above matter. I do not wish to participate in the Hepatitis B vaccination program.

I understand that due to my exposure to blood or other potentially infectious materials, I may be at risk of acquiring Hepatitis B virus (HBV) infection. I have been given the opportunity to be vaccinated with Hepatitis B vaccine. However, I decline the Hepatitis B vaccination at this time. I understand by declining this vaccine, I continue to be at risk of acquiring Hepatitis B, a serious disease. If in the future I continue to have exposure to blood or other potentially infectious materials and I want to be vaccinated with Hepatitis B vaccine, I understand that the immunization will remain available to me at no cost.

- Yes My job assignment includes contact with blood and body fluids. I wish to participate in the Hepatitis B Vaccination Program including the formal education. Please contact Health Services at (909) 274-4400 to make an appointment.

Signature: _____ Date: _____

Print name: _____

Department: _____

Position: _____

Further questions regarding information contained in this memo may be directed to Health Services at extension 4400.



Mt. San Antonio College

Worker's 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 Section 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. Your pre-designated 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 that 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. Otherwise, you will be treated by one of your employers' designated workers' compensation medical providers.

Employee Name: _____

Employee Address: _____

City: _____ State: _____ Zip Code: _____

I acknowledge receipt of this form and elect not 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.

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

Physician Name / Medical Group: _____ Phone: (____) _____ - _____

Physician / Medical Group Address: _____

City: _____ State: _____ Zip Code: _____

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

Insurance Company, Plan, or Fund providing Health coverage for non-occupational injuries or illnesses.

Employee Signature: _____ Date: ____ / ____ / ____

A Personal Physician must be willing to be pre-designated and treat you for a workers' compensation injury. Your personal physician should complete the remainder of this form and return it to Mt. San Antonio College.

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 pre-designated will be required pursuant to Title 8, California Code of Regulations, section 9780.1(a)(3).

Physician's Name / Medical Group: _____

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 TO MT. SAN ANTONIO COLLEGE 1100 N. GRAND AVENUE, WALNUT, CA 91789 or FAX TO 909.274.2994



California School Employee Tuberculosis (TB) Risk Assessment Questionnaire



(for pre-K, K-12 schools and community college employees, volunteers and contractors)

- Use of this questionnaire is required by California Education Code sections 49406 and 87408.6, and Health and Safety Code sections 1597.055 and 121525-121555.^
- The purpose of this tool is to identify **adults** with infectious tuberculosis (TB) to prevent them from spreading disease.
- **Do not repeat testing** unless there are **new** risk factors since the last negative test.
- **Do not treat for latent TB infection (LTBI) until active TB disease has been excluded:**
For individuals with signs or symptoms of TB disease or abnormal chest x-ray consistent with TB disease, evaluate for active TB disease with a chest x-ray, symptom screen, and if indicated, sputum AFB smears, cultures and nucleic acid amplification testing. A negative tuberculin skin test (TST) or interferon gamma release assay (IGRA) does not rule out active TB disease.

Name of Person Assessed for TB Risk Factors: _____

Assessment Date: _____

Date of Birth: _____

History of Tuberculosis Disease or Infection (Check appropriate box below)	
<input type="checkbox"/>	Yes <ul style="list-style-type: none"> • If there is a <u>documented</u> history of positive TB test or TB disease, then a symptom review and chest x-ray (if none performed in the previous 6 months) should be performed at initial hire by a physician, physician assistant, or nurse practitioner. If the x-ray does not have evidence of TB, the person is no longer required to submit to a TB risk assessment or repeat chest x-rays.
<input type="checkbox"/>	No (Assess for Risk Factors for Tuberculosis using box below)

TB testing is recommended if <u>any</u> of the 3 boxes below are checked	
<input type="checkbox"/>	One or more sign(s) or symptom(s) of TB disease <ul style="list-style-type: none"> • TB symptoms include prolonged cough, coughing up blood, fever, night sweats, weight loss, or excessive fatigue.
<input type="checkbox"/>	Birth, travel, or residence in a country with an elevated TB rate for at least 1 month <ul style="list-style-type: none"> • Includes countries <u>other than</u> the United States, Canada, Australia, New Zealand, or Western and North European countries. • Interferon gamma release assay (IGRA) is preferred over tuberculin skin test (TST) for non-US-born persons.
<input type="checkbox"/>	Close contact to someone with infectious TB disease during lifetime
Treat for LTBI if TB test result is positive and active TB disease is ruled out	

^The law requires that a health care provider administer this questionnaire. A health care provider, as defined for this purpose, is any organization, facility, institution or person licensed, certified or otherwise authorized or permitted by state law to deliver or furnish health services. A Certificate of Completion should be completed after screening is completed (page 3).

California School Employee Tuberculosis (TB) Risk Assessment User Guide

(for pre-K, K-12 schools and community college employees, volunteers and contractors)

Background

California law requires that school staff working with children and community college students be free of infectious tuberculosis (TB). These updated laws reflect current federal Centers for Disease Control and Prevention (CDC) recommendations for targeted TB testing. Enacted laws, AB 1667, effective on January 1, 2015, SB 792 on September 1, 2016, and SB 1038 on January 1, 2017, require a TB risk assessment be administered and if risk factors are identified, a TB test and examination be performed by a health care provider to determine that the person is free of infectious tuberculosis. The use of the California School Employee TB Risk Assessment and the Certificate of Completion, developed by the California Department of Public Health (CDPH) and California TB Controllers Association (CTCA) are also required.

AB 1667 impacted the following groups on 1/1/2015:

1. Persons employed by a K-12 school district, or employed under contract, in a certificated or classified position (California Education Code, Section 49406)
2. Persons employed, or employed under contract, by a private or parochial elementary or secondary school, or any nursery school (California Health and Safety Code, Sections 121525 and 121555).
3. Persons providing for the transportation of pupils under authorized contract in public, charter, private or parochial elementary or secondary schools (California Education Code, Section 49406 and California Health and Safety Code, Section 121525).
4. Persons volunteering with frequent or prolonged contact with pupils (California Education Code, Section 49406 and California Health and Safety Code, Section 121545).

SB 792 impacted the following group on 9/1/2016:

Persons employed as a teacher in a child care center (California Health and Safety Code Section 1597.055).

SB 1038 impacted the following group on 1/1/2017:

Persons employed by a community college district in an academic or classified position (California Education Code, Section 87408.6).

Testing for latent TB infection (LTBI)

Because an interferon gamma release assay (IGRA) blood test has increased specificity for TB infection in persons vaccinated with BCG, IGRA is preferred over the tuberculin skin test (TST) in these persons. Most persons born outside the United States have been vaccinated with BCG.

Previous or inactive tuberculosis

Persons with a previous chest radiograph showing findings consistent with previous or inactive TB should be tested for LTBI. In addition to LTBI testing, evaluate for active TB disease.

Negative test for LTBI does not rule out TB disease

It is important to remember that a negative TST or IGRA result does not rule out active TB disease. In fact, a negative TST or IGRA in a person with active TB can be a sign of extensive disease and poor outcome.

Symptoms of TB should trigger evaluation for active TB disease

Persons with any of the following symptoms that are otherwise unexplained should be medically evaluated: cough for more than 2-3 weeks, fevers, night sweats, weight loss, hemoptysis.

Most patients with LTBI should be treated

Because testing of persons at low risk of LTBI should not be done, persons that test positive for LTBI should generally be treated once active TB disease has been ruled out. However, clinicians should not be compelled to treat low risk persons with a positive test for LTBI.

Emphasis on short course for treatment of LTBI

Shorter regimens for treating LTBI have been shown to be more likely to be completed and the 3 month 12-dose regimen has been shown to be as effective as 9 months of isoniazid. Use of these shorter regimens is preferred in most patients. Drug-drug interactions and contact to drug resistant TB are typical reasons these regimens cannot be used.

Repeat risk assessment and testing

If there is a documented history of positive TB test or TB disease, then a symptom review and chest x-ray should be performed at initial hire. Once a person has a documented positive test for TB infection that has been followed by a chest x-ray (CXR) that was determined to be free of infectious TB, the TB risk assessment (and repeat x-rays) is no longer required.

Repeat risk assessments should occur every four years (unless otherwise required) to identify any additional risk factors, and TB testing based on the results of the TB risk assessment. Re-testing should only be done in persons who previously tested negative, and have new risk factors since the last assessment.

Please consult with your local public health department on any other recommendations and mandates that should also be considered.

Certificate of Completion Tuberculosis Risk Assessment and/or Examination

To satisfy **job-related requirements** in the California Education Code, Sections 49406 and 87408.6 and the California Health and Safety Code, Sections 1597.055, 121525, 121545 and 121555.

First and Last Name of the person assessed and/or examined:

Date of assessment and/or examination: _____ mo./_____ day/_____ yr.

Date of Birth: _____ mo./_____ day/_____ yr.

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

X _____

Signature of Health Care Provider completing the risk assessment and/or examination

Please print, place label or stamp with Health Care Provider Name and Address (include Number, Street, City, State, and Zip Code):



California School Employee Tuberculosis Risk Assessment Frequently Asked Questions



California law requires that school staff working with children and community college students be free of infectious tuberculosis (TB). These updated laws reflect current recommendations for targeted TB testing from the federal Centers for Disease Control and Prevention (CDC), the California Department of Public Health (CDPH), the California Conference of Local Health Officers and the California Tuberculosis Controllers Association (CTCA).

What specifically did [AB 1667](#) change on January 1, 2015?

1. Replaces the mandated TB examination on initial employment with a TB risk assessment, and TB testing based on the results of the TB risk assessment, for the following groups:
 - a. Persons initially employed by a school district, or employed under contract, in a certificated or classified position (California Education Code, Section 49406)
 - b. Persons initially employed, or employed under contract, by a private or parochial elementary or secondary school or any nursery school (California Health and Safety Code, Sections 121525 and 121555)
 - c. Persons providing for the transportation of pupils under authorized contract (California Health and Safety Code, Section 121525)
2. Replaces the mandated TB examination at least once each four years of school employees who have no identified TB risk factors or who test negative for TB infection with a TB risk assessment, and TB testing based on the TB risk assessment responses. (California Education Code, Section 49406 and California Health and Safety Code, Section 121525)
3. Replaces mandated TB examination (within the last four years) of volunteers with "frequent or prolonged contact with pupils" in private or parochial elementary or secondary schools, or nursery schools (California Health and Safety Code, Section 121545) with a TB risk assessment administered on initial volunteer assignment, and TB testing based on the results of the TB risk assessment.
4. For school district volunteers with "frequent or prolonged contact with pupils," mandates a TB risk assessment administered on initial volunteer assignment and TB testing based on the results of the TB risk assessment. (California Education Code, Section 49406)

What specifically did [SB 792](#) change on September 1, 2016?

California Health and Safety Code, Section 1597.055 requires that persons hired as a teacher in a child care center must provide evidence of a current certificate that indicates freedom from infectious TB as set forth in California Health Safety Code, Section 121525.

What specifically does [SB 1038](#) change on January 1, 2017?

California Education Code, Section 87408.6 requires persons employed by a community college in an academic or classified position to submit to a TB risk assessment developed by CDPH and CTCA and, if risk factors are present, an examination to determine that he or she is free of infectious TB; initially upon hire and every four years thereafter.



California School Employee Tuberculosis Risk Assessment Frequently Asked Questions



Who developed the school staff and volunteer TB risk assessment?

The California Department of Public Health (CDPH) and the California Tuberculosis Controllers Association (CTCA) jointly developed the TB risk assessment. The risk assessment was adapted from a form developed by Minnesota Department of Health TB Prevention and Control Program and the Centers for Disease Control and Prevention.

Who may administer the TB risk assessment?

Per California Education and Health and Safety Codes, the TB risk assessment is to be administered by a health care provider. The risk assessment should be administered face-to-face. The practice of allowing employees or volunteers to self-assess is discouraged.

What is a "health care provider"?

A "health care provider" means any organization, facility, institution or person licensed, certified or otherwise authorized or permitted by state law to deliver or furnish health services.

If someone is a new employee and has a TB test that was negative, would he/she need to also complete a TB risk assessment?

Check with your employer about what is needed at the time of hire.

If someone transfers from one K-12 school or school district to another school or school district, would he/she need to also complete a TB risk assessment?

Not if that person can produce a certificate that shows he or she was found to be free of infectious tuberculosis within 60 days of initial hire, or the school previously employing the person verifies that the person has a certificate on file showing that the person is free from infectious tuberculosis.

If someone does not want to submit to a TB risk assessment, can he/she get a TB test instead? Yes,

a TB test, and an examination if necessary, may be completed instead of submitting to a TB risk assessment.

If someone has a positive TB test, can he/she start working before the chest x-ray is completed? No,

the x-ray must be completed and the person determined to be free of infectious TB prior to starting work.

If someone has a positive TB test, does he/she need to submit to a chest x-ray every four (4) years?

No, once a person has a documented positive TB test followed by an x-ray, repeat x-rays are no longer required every four years. If an employee or volunteer becomes symptomatic for TB, then he/she should promptly seek care from his/her health care provider.



California School Employee Tuberculosis Risk Assessment Frequently Asked Questions



What screening is required for someone who has a history of a positive TB test or TB disease at hire?

If there is a documented history of positive TB test or TB disease, then a symptom review and chest x-ray (if none performed in previous 6 months) should be performed at initial hire by a physician, physician assistant, or nurse practitioner. Once a person has a documented positive test for TB infection that has been followed by an x-ray that was determined to be free of infectious TB, the TB risk assessment (and repeat x-rays) is no longer required. If an employee or volunteer becomes symptomatic for TB, then he/she should seek care from his/her health care provider.

For volunteers, what constitutes “frequent or prolonged contact with pupils”?

Examples of what may be considered “frequent or prolonged contact with pupils” include, but are not limited to, regularly-scheduled classroom volunteering and field trips where cumulative face-to-face time with students exceeds 8 hours.

Who may sign the Certificate of Completion?

- If the patient has no TB risk factors then the health care provider completing the TB risk assessment may sign the Certificate of Completion.
- If a TB test is performed and the result is negative, then the licensed health care provider interpreting the TB test may sign the Certificate.
- If a TB test is positive and an examination is performed, only a physician, physician assistant, or nurse practitioner may sign the Certificate.

What does “determined to be free of infectious tuberculosis” mean on the Certificate of Completion?

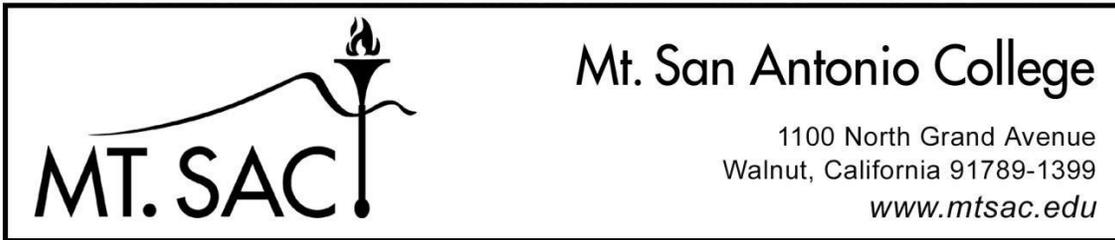
“Determined to be free of infectious TB” means that a physician, physician assistant, or nurse practitioner has completed the TB examination and provided any necessary treatment so that the person is not contagious and cannot pass the TB bacteria to others. The TB examination for active TB disease includes a chest x-ray, symptom assessment, and if indicated, sputum collection for acid-fast bacilli (AFB) smears cultures and nucleic acid amplification testing.

What if I have TB screening or treatment questions?

Consult the federal Centers for Disease Control and Prevention’s *Latent Tuberculosis Infection: A Guide for Primary Health Care Providers* (2013) (<http://www.cdc.gov/tb/publications/LTBI/default.htm>). If you have specific TB screening or treatment questions, please contact your local TB control program (<http://www.ctca.org/locations.html>).

Who may I contact to get further information or to download the TB risk assessment?

- California Tuberculosis Controllers’ Association
<https://www.ctca.org/providers/>
- California Department of Public Health, Tuberculosis Control Branch: (510) 620-3000
<https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/TBCB.aspx>
- California School Nurses Organization: (916) 448-5752 or email csno@csno.org
<http://www.csno.org/>



TO: MT. SAC ADJUNCT FACULTY
FROM: PAYROLL DEPARTMENT
SUBJECT: ADJUNCT FACULTY RETIREMENT PLANS

Adjunct faculty have the option of two retirement plans: CalSTRS or the 457(b) Social Security Alternative Plan (SSAP). Adjunct faculty do not have the option to contribute to social security.

California State Teachers' Retirement System (CalSTRS or STRS) is a defined benefit program (pension plan) that can provide a lifetime monthly pension check if the member meets all eligibility requirements at retirement. The retirement benefit is based on a formula, not based on the accumulated contributions.

Mandatory CalSTRS Enrollment

If you are a member of CalSTRS from another public school, college or university, you will automatically be enrolled with CalSTRS.

Permissive Election Enrollment

All new adjunct faculty are provided a Permissive Membership form to elect or decline. If you elect membership, you must notify the HR or Payroll departments at other districts that you have become a CalSTRS member. If you decline, you will automatically be enrolled in the district's SSAP for your retirement plan. Adjunct faculty elect membership into CalSTRS at any time while employed at a district. See HR for the form.

The district's 457(b) Social Security Alternative Plan (SSAP) is the default retirement plan for employees NOT participating in the district's pension plans. Currently, the district's SSAP is a 457(b) plan with our third party administrator, National Benefits Services. The retirement benefit is the accumulated contributions in the participant's account plus accrued interest. Participants may withdraw or rollover their 457(b) funds upon separation with our district.

ALL ADJUNCT FACULTY MEMBERS MUST COMPLETE THE CALSTRS PERMISSIVE ELECTION ES 350 FORM TO ELECT OR DECLINE MEMBERSHIP INTO CALSTRS. PLEASE RETURN FORM(S) WITH YOUR ADJUNCT HIRING PAPERWORK.

Mt. SAC ADJUNCT RETIREMENT PLANS



Applicable to adjunct faculty who permissively elect to join CalSTRS or adjunct faculty who are current CalSTRS members.

CalSTRS provides a defined benefit plan (pension plan) eligible members can receive a **lifetime retirement benefit** determined by a set formula:

service credit x age factor x final compensation = RETIREMENT BENEFIT
--

- Must have 5 years of service credit to receive retirement benefit
- Must meet CalSTRS minimum retirement age
- CalSTRS members do NOT pay into Social Security
- Adjunct faculty may permissively elect to join CalSTRS at ANY time
- CalSTRS members must contribute to their CalSTRS account for all CalSTRS positions performing creditable service with other employers

CalSTRS Benefit Structure*	2% @ 60 Performed creditable service before 1/1/13	2% @ 62 Performed creditable service on or after 1/1/13
Minimum Retirement Age	Age 55 Or Age 50 w/ 30 yrs of Service Credit	Age 55
Member Contribution	10.25%**	10.205%**
*A member's benefit structure is based on when they initially performed creditable service (i.e. teaching), even if they did not elect to be a member at that time.		
**Contribution rates for 2019-2020. Contribution rates are established by statute.		

- CalSTRS members will receive an annual statement of their CalSTRS account
- CalSTRS members can create their myCalSTRS account online to track their contributions and service credit accrual
- Member Benefit Education videos:
www.calstrs.com/member-benefit-education

CalSTRS
Phone: 800-228-5453
www.calstrs.com/

457(b) Social Security Alternative Plan

Applicable to adjunct faculty who do NOT participate in CalSTRS.

The District must provide an alternative social security plan for those not participating in the defined benefit plan.

- **National Benefit Services** is the district's third-party administrator for the 457(b) Social Security Alternative Plan
- Participants do NOT pay into Social Security
- Participants contribute 4.5% of earnings; Employers contribute 3% in to employee's 457(b) account

	Employee Contribution	Employer Contribution
Social Security Alternative Plan	4.5%	3%*
*Employer's contribution is deposited into employee's 457(b) account for a total of 7.5%.		

- Participants will receive a quarterly statement from National Benefit Services
- Participants may withdraw 100% of the account balance *after* separation with the district

National Benefit Services
Phone: 1.800.274.0503
www.nbsbenefits.com/403b

NOTE: Information on this page is subject to change per the retirement laws, retirement systems or plans without notice.

For questions or information about retirement, please contact Retirement Specialist, JenMay Anol, at janol@mtsac.edu or 909.274.5767.

PERMISSIVE ELECTION FORM

INSTRUCTIONS and SAMPLE

ALL ADJUNCT MUST COMPLETE A CALSTRS PERMISSIVE MEMBERSHIP FORM.

1. Employee completes Section 1, 2 and 3 (pages 1 and 2).
2. A selection must be marked for ELECT membership or DECLINE membership.
3. If electing to join CalSTRS:
 - LEAVE THE MEMBERSHIP DATE FIELD BLANK. Payroll will determine the membership date based on information found in various systems.
 - Review and complete the SSA 1945 form: Statement Concerning Your Employment in a Job Not Covered by Social Security
4. SIGN and DATE the form on Page 2 .The signature date helps determine the membership date if necessary.
5. If the member needs to make a correction to their election, it's best that they COMPLETE A NEW FORM to avoid any confusion.

Permissive Membership
ES 0350 REV 03/20

PAGE 1

[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:

LEAVE MEMBERSHIP DATE BLANK

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 date of the election, the date of the election made, or the first day of employment, whichever is the most beneficial, valid membership date.

I decline membership in the CalSTRS Defined Benefit Program. I understand that I can elect membership in the program while I am employed to perform creditable service.

COMPLETE SECTION 1.

COMPLETE SECTION 2. A SELECTION IS REQUIRED.

SIGNATURE AND DATE REQUIRED.

PAGE 2

Client ID: OR SSN:

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.

Permissive Membership
ES 0350 REV 03/20



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

[For CalSTRS' Official Use Only]

**PERMISSIVE MEMBERSHIP ELECTION AND/OR ACKNOWLEDGEMENT OF RECEIPT
OF CALSTRS DEFINED BENEFIT PROGRAM MEMBERSHIP INFORMATION**

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

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

Provide either your CalSTRS Client ID or Social Security number.

CLIENT ID

SOCIAL SECURITY NUMBER

LAST NAME

FIRST NAME

MI

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

CITY

STATE

ZIP CODE

DATE OF BIRTH (MM/DD/YYYY)

EMAIL ADDRESS

TELEPHONE

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

Check One:

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

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

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

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

I understand that I can elect membership in the CalSTRS Defined Benefit Program at any time while I am employed to perform creditable service.



Section 3: Required Signature (to be completed by employee)

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

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

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 Mt. San Antonio College	COUNTY AND DISTRICT CODE 19 630
EMPLOYER OFFICIAL'S NAME AND TITLE	

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

Employee Name _____ **Employee ID#** _____
Employer Name Mt. San Antonio College **Employer ID#** 19-630

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

Windfall Elimination Provision

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

Government Pension Offset Provision

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

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

For More Information

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

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

Signature of Employee _____ **Date** _____

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

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

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

Employers must:

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

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

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

Direct Deposit Authorization

Step 1

Check the Appropriate Box

<input type="checkbox"/> Employee	<input type="checkbox"/> Vendor	<input type="checkbox"/> Student (Financial Aid)
--	--	---

Check the Appropriate Box

<input type="checkbox"/> New Request	<input type="checkbox"/> Changed Information	<input type="checkbox"/> Cancel Direct Deposit
---	---	---

Step 2

Employee/Student/Vendor Information

Last Name or Vendor Name	First Name	Middle Initial	
Employee/Student/Vendor I.D. Number (Required)	A	E-mail Address	
Address			
City	State	Zip Code	
Country	Daytime Telephone Number		

Authorization

1. I authorize Mt. San Antonio College to direct deposit funds to my account in the financial institution as indicated in Step 3 below. If funds to which I am **not** entitled are deposited in my account, I authorize the College to initiate a correcting (debit) entry. I understand that the authorization may be rejected or discontinued by the College at any time. If any of the above information changes, I will promptly complete a new authorization agreement. If the direct deposit is not stopped before closing an account, funds payable to me will be returned to the College for distribution. This will delay my payment.
2. This authorization remains in effect until the College receives written notification of change or cancellation from you or your financial institution OR 18 months has elapsed since the date you were last paid by the College.
3. The College reserves the right to recall or adjust any deposits improperly created and deposited to my account.
4. I will hold the College harmless for any liability to pay charges for insufficient fund transactions that result from failure within the Automated Clearing House network to correctly and timely deposit monies into my account.

Disclosure Statement

The first time a Payroll payment is processed it must go through a "pre-note" or "test run" to our bank. Therefore, your first payment after requesting direct deposit may be a check. The pre-note allows our bank the opportunity to notify us if there is a problem with the banking information that we entered. The pre-note period must occur with Accounts Payable/Student Accounts checks as well. If the pre-note does not occur on the Accounts Payable system before the processing of a check, then the first payment processed from Accounts Payable may be a check as well with all subsequent payments being directly deposited.

As the account holder, I authorize, by signing below, credits to be made to my bank account listed here

ACCOUNT HOLDER SIGNATURE:	DATE:
----------------------------------	--------------

Step 3

You must verify that your bank is a member of an Automated Clearing House (ACH). Failure to do so could delay the processing of your payment. You must attach a voided check or have your bank complete the bank information and the account holder must sign below.

↓	Staple voided check here (DO NOT attach a deposit slip) OR Have bank representative complete here	↓	
Staple Here	TO BE COMPLETED BY YOUR BANK		
	NAME OF YOUR BANK:		
	ACCOUNT HOLDER NAME(S):		
	<input type="checkbox"/> CHECKING <input type="checkbox"/> SAVINGS	ACCOUNT NUMBER:	ROUTING NUMBER:
	BANK REPRESENTATIVE NAME:		
	BANK REPRESENTATIVE SIGNATURE:		DATE:

Your Advocate. Your Partner. Your CTA.

Thank you for choosing a career in education. While it's personally rewarding, it's also professionally demanding. That's why NEA, CTA and your local association will provide you the support you need to be great at what you do. Being a member connects you with other educators. Together, we've been the most powerful voice for students and public education in California since 1863. And together, we still are. **We do this by:**

- Negotiating fair salaries, health care and other benefits
- Improving learning and working conditions
- Leading student-centered educational improvements
- Enhancing and defending your professional rights
- Supporting your professional practice with conferences, workshops, grants and scholarships
- Providing cost-saving benefits designed just for educators

PERSONAL INFORMATION

CTA Membership ID or Previous Employer/School District _____

First Name _____ MI _____

Last Name _____

Last 4 of SSN _____

Home Address _____ Apt _____

City _____

State _____ Zip _____

Land Line _____

Cell Phone* _____
* See next page for information

Home Email _____

MEMBERSHIP INFORMATION

Local Association _____

Current Employer/School District _____

Hire Date _____ Primary Employer? Yes No

If no, list employer _____

Job Title _____

Building/Work Site _____

FACULTY ASSIGNMENT INFORMATION

- Category 1 Full-Time
- Category 4 Part-Time or Hourly

FOR OFFICE USE ONLY
ANNUAL DUES AMOUNTS

NEA: _____

CTA/CCA: _____

LEA: _____

NEA FUND: _____

TOTAL \$ _____

NEA FUND DEDUCTION AUTHORIZATION (Optional)

I agree to contribute \$_____ annually to the NEA Fund. The NEA Fund for Children and Public Education (NEA Fund) collects voluntary contributions from Association members and uses these contributions for political purposes, including, but not limited to, making contributions to and expenditures on behalf of friends of public education who are candidates for federal office. ** See reverse for more information.

CTA/ABC & INDEPENDENT EXPENDITURES ALLOCATION (Optional)

Designated portions of CTA dues are allocated to the Association for Better Citizenship (CTA/ABC) and to Independent Expenditures (IE) through which CTA provides financial support for education-related issues (CTA/ABC) and CTA-endorsed bipartisan candidates for local and state offices (CTA/ABC and IE).

- Please indicate if you choose not to allocate a portion of your dues to the CTA/ABC and the IE account and want all your dues to remain in the general fund.

CTA VOLUNTARY CONTRIBUTION

All CTA dues include a \$20 voluntary contribution per year to help fund CTA advocacy efforts and fund the CTA Foundation for Teaching and Learning, which provides scholarships to members and supports teacher-led efforts to improve public schools. To opt out of the voluntary contribution, complete a Voluntary Contribution Change Form. Forms are available at www.cta.org/contribution, from your local membership contact or via email at membership@cta.org.

MEMBERSHIP, DUES PAYMENT AND DUES DEDUCTION AUTHORIZATION

YES, I want to join with my fellow employees and be a committed member of the Local Association, the California Teachers Association (CTA), and the National Education Association (NEA). I hereby request and voluntarily accept membership in these associations and agree to abide by the Constitution and Bylaws of all three associations, as they may be amended from time to time. I support the Local Association in its role as my exclusive representative in collective bargaining over wages, hours, and other terms and conditions of employment.

I hereby (1) agree to pay annual dues uniformly required for membership in the Local, CTA, and NEA; and (2) request and authorize my Employer to deduct from my pay in each pay period, and transmit to CTA or its designated agent, a pro rata portion of the annual dues required for membership in the Local, CTA, and NEA, unless I pay dues by check. I fully understand that the dues required for membership in the three associations are subject to periodic change by the associations' governing bodies and authorize dues payment on a continuing basis, and regardless of my membership status, unless my obligation to do so ends under one of the circumstances below. This agreement to pay dues continues from year to year, regardless of my membership status, unless: I revoke it by sending written notice via U.S. mail to CTA Member Services, P.O. Box 4178, Burlingame, CA 94011, not less than thirty (30) days and not more than sixty (60) days before the annual anniversary date of this agreement; my employment with the Employer ends; or as otherwise required by law.

I understand that this agreement is voluntary and is not a condition of employment and that I have the legal right not to sign this agreement.

Member Signature _____ Date _____



DEMOGRAPHIC INFORMATION *(Optional)*

Ethnicity	<input type="checkbox"/> African American	<input type="checkbox"/> Hispanic	Gender	<input type="checkbox"/> Female	Birthdate _____	
	<input type="checkbox"/> American Indian/ Alaska Native	<input type="checkbox"/> Multi-Ethnic		<input type="checkbox"/> Male	(mm/dd/yyyy)	
	<input type="checkbox"/> Asian	<input type="checkbox"/> Native Hawaiian/ Pacific Islander		<input type="checkbox"/> Non-Binary	Social Media Used:	
	<input type="checkbox"/> Caucasian	<input type="checkbox"/> Other			<input type="checkbox"/> Instagram	<input type="checkbox"/> Pinterest
		<input type="checkbox"/> Unknown			<input type="checkbox"/> Facebook	<input type="checkbox"/> Twitter

HOW CAN WE BEST SUPPORT YOU? *(Optional)*

1. What year did you begin working in higher education?

(YYYY)

2. I am:

- Already a member
- Joining the Association today
- Interested in receiving more information about membership

3. Our Association provides resources and support to members to ensure student success. What areas of support would be most useful to help you and your students succeed?

- Social and racial justice
- Effective pedagogy
- Community engagement
- Fully funded colleges and universities
- Education policy - *policy that impacts your college/ university at the local, state or national level*
- Political advocacy - *advocate for policies that ensure all students get the opportunities that they deserve*

4. Our Association advocates for conditions that retain high-quality educators for every student. Which of these are you interested in learning about?

- Salary
- Educator Rights & Responsibilities
- Health Care Benefits
- Pensions and Retirement Security
- Student Debt and/or Finances
- Stretching Your Paycheck
- Working Conditions

MORE INFORMATION

*By providing my phone number, I understand that the NEA and its affiliates including CTA, the Local, NEA Member Benefits, and NEA360 may use automated calling technologies and/or text message me on my cellular phone on a periodic basis. NEA and its affiliates will never charge for text message alerts. Carrier message and data rates may apply to such alerts. Text STOP in response to an NEA, CTA or Local text message to stop receiving the association's messages.

**Only U.S. citizens or lawful permanent residents may contribute to the NEA Fund. Contributions to the NEA Fund are voluntary; making a contribution is neither a condition of employment nor membership in the Association, and members have the right to refuse to contribute without suffering any reprisal. Although the NEA Fund requests an annual contribution of \$50, this is only a suggestion. A member may contribute more or less than the suggested amount, or may contribute nothing at all, without it affecting his or her membership status, rights or benefits in NEA or any of its affiliates. Contributions to the NEA Fund are not deductible as charitable contributions for federal income tax purposes. Federal law requires political committees to report the name, mailing address, occupation, and name of employer for each individual whose contributions aggregate in excess of \$200 in a calendar year.



New Health Insurance Marketplace Coverage

Options and Your Health Coverage

Form Approved

OMB No. 1210-0149
expires 5-31-2020

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that does not meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.¹

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution -as well as your employee contribution to employer-offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact Melissa Aguirre (909) 274-5419 or Norma Vizcarra (909) 274-5872

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

¹ An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name Mt. San Antonio Community College District		4. Employer Identification Number (EIN) 95-600-21-31	
5. Employer address 1100 N. Grand Ave.		6. Employer phone number (909) 274-7500	
7. City Walnut		8. State CA	9. ZIP code 91789
10. Who can we contact about employee health coverage at this job? Melissa Aguirre (909) 274-5419 or Norma Vizcarra (909) 274-5872			
11. Phone number (if different from above) N/A		12. Email address maguirre@mtsac.edu; nvizcarra4@mtsac.edu	

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:

All employees. Eligible employees are:

Some employees. Eligible employees are:

Permanent full-time and permanent part-time employees working a 50% or greater position.

Adjunct Faculty must have worked four consecutive semesters, Fall or Spring, and must maintain three(3) LHE's (Lecture Hours Equivalent) for credit adjunct faculties and six (6) hours of instruction per week for non-credit adjunct faculties to qualify for health coverage.

- With respect to dependents:

We do offer coverage. Eligible dependents are:

Current spouse/domestic partner; natural, adopted, step or registered domestic partner's children up to age 26. Disabled children of any age if enrolled prior to age 26 and children up to age 26 for whom the subscriber has assumed a parent-child relationship and is considered the primary parent.

We do not offer coverage.

If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, [HealthCare.gov](https://www.healthcare.gov) will guide you through the process. Here's the employer information you'll enter when you visit [HealthCare.gov](https://www.healthcare.gov) to find out if you can get a tax credit to lower your monthly premiums.

The information below corresponds to the Marketplace Employer Coverage To I. Completing this section is optional for employers, but will help ensure employees understand their coverage choices.

13. Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?

Yes (Continue)

13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage? _____ (mm/dd/yyyy) (Continue)

No (STOP and return this form to employee)

14. Does the employer offer a health plan that meets the minimum value standard*?

Yes (Go to question 15) No (STOP and return form to employee)

15. For the lowest-cost plan that meets the minimum value standard* offered only to the employee (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/ she the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.

. How much would the employee have to pay in _____ for this plan? \$ _____

. How often? Weekly Every 2 weeks Twice a month Monthly Quarterly Yearly

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and return form to employee.

16. What change will the employer make for the new plan year? _____

Employer won't offer health coverage

Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)

a. How much would the employee have to pay in premiums for this plan? \$ _____

b. How often? Weekly Every 2 weeks Twice a month Monthly Quarterly Yearly

* An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36 (c)(2)(C)(ii) of the Internal Revenue Code f 19 6)



MT. SAN ANTONIO COLLEGE
Human Resources

TO: Mt. San Antonio College Employees
FROM: Risk Management & Safety Department
SUBJECT: Employee Asbestos Notification

In accordance with Health and Safety Code Section 25915.2, the College is required to annually notify employees of asbestos containing materials (ACM) in the work place.

Asbestos is a naturally occurring mineral fiber found in rocks. Asbestos fibers are divided into two groups, serpentine and amphibole. The most common forms are chrysotile asbestos (from serpentine rock), amosite and crocidolite (from amphibole rock). Because asbestos fibers are strong, conduct heat and cold poorly, and are resistant to chemical corrosion, it was commonly used as fireproofing and as an insulator in many building construction materials.

In order for asbestos to become a health risk, asbestos fibers must be released from the material and be present in the air for us to breathe. Asbestos is linked with lung disease and the symptoms of the disease do not appear until 15 to 30 years after exposure. However, most people exposed to small amounts of asbestos, as we all are in our daily lives, do not develop asbestos-related problems. Asbestosis, which is scarring of the lung, lung cancer and mesothelioma, a cancer of the lining of the chest or abdominal wall, are also linked with asbestos exposure. Occupational exposure of asbestos and lung disease has been linked to miners and manufacturing workers. Smoking with asbestos exposure increases the risk of lung disease.

The majority of buildings on campus that contain asbestos were constructed prior to 1979. The only asbestos contained in these buildings is in the insulation of heating and ventilation pipes, fireproof interior walls, and 9" x 9" floor tiles. The asbestos in its current undisturbed condition does not pose a health hazard. However, it is important for employees to follow proper work practices to minimize the potential for disturbing the asbestos. Employees should not drill holes, hang plants or other objects from walls and ceilings made of ACM. Do not disturb ACM when replacing light bulbs. If you find ACM that has been damaged, immediately report it to your supervisor. Your supervisor will contact the Facilities Department for remediation. If any employee is unsure whether

certain materials contain ACM, the employee should request assistance from their supervisor.

Asbestos containing materials pose no threat to your health unless asbestos fibers become airborne due to material aging, deterioration, or as the result of damage. Only persons authorized and properly trained should perform work which may disturb ACM. Asbestos conditions may vary, and where ACM were identified in building surveys, they were generally in good condition, enclosed, encapsulated or of a type not likely to release fibers unless disturbed.

Any employee may review the asbestos survey report conducted by the College and a qualified outside contractor. Results of bulk sampling and air monitoring have been conducted in all buildings on campus. All asbestos-related data will be available during normal working hours in the office of Administrative Services.

Please acknowledge that you have read the information contained in this memo by signing and returning to **Human Resources**.

Mt. San Antonio College
EMPLOYEE ASBESTOS NOTIFICATION

I, _____, hereby acknowledge receipt of the ***Employee Asbestos Notification***. I have read and understand the information contained in the Employee Asbestos Notification.

Print Name

Date

Signature



TO: All Mt. SAC Personnel
SUBJECT: Family Care and Medical Leave

Any employee who has been employed by Mt. San Antonio College for at least 12 months and who has worked at least 1,250 hours with the District during the previous 12 month period, shall be eligible to take family care or medical leave pursuant to applicable state and federal law and this administrative regulation. Full-time instructors are deemed to meet the 1,250 hour test. (29 U.S.C. 2611; Government Code 12945.2, 29 C. F. R. 825. 110)

Family care and medical leave may be used for the following reasons:

1. For the birth of the employee's child, and to care for the newborn child. (29 U.S.C. 2612 Government Code 19245.2)
2. For the placement of a child with the employee for foster care or in connection with the employee's adoption of a child. (29 U.S.C. 2612; Govt. Code 12945.5)
3. To care for the employee's child, parent, or spouse with a serious health condition. (29 U.S.C. 2612; Govt. Code 12945.2)
4. Due to the employee's own serious health condition that makes the employee unable to perform the functions of his/her position. (29 U.S.C. 2612; Govt. Code 12945.2)
5. Due to a qualifying exigency arising out of the fact the employee's spouse, son, daughter, or parent is a covered military member on active duty (or has been notified of an impending call or order to active duty) in support of a contingency operations. (29 U.S.C. 2612)
6. To care for a covered service member with a serious injury or illness if the employee is the spouse, son, daughter, parent, or next of kin of the servicemember. This can amount to 26 weeks of unpaid leave during the 12-month period. (29 U.S.C. 2612)

Definitions

For purposes of this Administrative Regulation, "child" means a biological, adopted, or foster son or daughter, a stepson or stepdaughter, a legal ward, or a child of a person standing in loco parentis as long as the child is under 18 years of age or an adult dependent child. (29 U.S.C. 2611; Govt. Code 12945.2)

"Parent" means a biological, foster, or adoptive parent, a stepparent, a legal guardian, or other person who stood in loco parentis to an employee when the employee was a child (29 U.S.C. 2611; Govt. Code 12945.2)

"Next of kin of a covered service member" means nearest blood relative of an injured servicemember, other than the covered servicemember's spouse, parent, son or daughter, in following in following order of priority: blood relatives who have been granted legal custody of servicemember by court decree or statute, brothers and sisters, grandparents, aunts, and uncles, and first cousins, unless covered servicemember has specifically designated in writing another blood relative as his or her nearest blood relative for purposes of military caregiver leave under the FMLA.

"Serious health condition" means an illness, injury, impairment, physical and/or mental condition that involves either:

1. Inpatient care in a hospital, hospice, or residential health care facility and any subsequent treatment in connection with such inpatient care; or
2. Continuing treatment or continuing supervision by a health care provider as defined in 29 Code of Federal Regulations section 825.114.

"Qualifying exigency" allows for an eligible employee to take FMLA leave while the employee's spouse, son, daughter or parent (the "covered military member") is on covered active duty or call to active duty status. There are eight general categories of qualifying exigencies:

1. Short-notice deployment
2. Military events and related activities
3. Childcare and school activities
4. Financial and legal arrangements
5. Counseling
6. Rest and recuperation
7. Post-deployment activities
8. Additional activities

Duration

Family care and medical leave shall not exceed 12 workweeks during any 12-month period, except as identified in item 6 above, in which case the maximum period of leave could be up to 26 workweeks. The 12-month period for calculating leave entitlement shall commence on the date the employee's first family care or medical leave begins. The 12 workweeks of family care and medical leave to which an employee is entitled under state law shall run concurrently with the 12 workweeks of family care and medical leave to which an employee is entitled under federal law, except that any leave taken under state law for family care or medical leave shall run consecutively to an employee's leave entitlement on account of pregnancy, childbirth, and related medical conditions.

If both parents of a child work for the District, their family care and medical leave related to the birth or placement of the child shall be limited to a total of 12 weeks during the 12-month period following the birth or placement of child. (Government Code 12945.2)

An employee may take leave intermittently or on a reduced leave schedule if the leave is being taken due to an employee's own serious health condition or for the purpose of caring for a spouse, child, parent with a serious health condition provided that taking leave in this manner is medically necessary. (29 U.S.C. 2612, Gov. Code 12945.2)

An employee may also take leave intermittently for the birth, adoption, or placement of a child for foster care; however such leaves shall be taken for a minimum duration of two consecutive weeks; except that an employee shall be entitled to leaves of less than two consecutive weeks on two occasions within 12 months following the birth of the child. (2 Cal. Code Regs. 7297.3)

The District may temporarily assign an employee requesting intermittent leave to an alternative position with equivalent pay and benefits that better accommodates the employee's intermittent or reduced leave schedule. (29 C.F.R. 825.117)

Leave taken for a birth, or placement for adoption or foster care, must be initiated within one year of the birth or placement.

Terms of Leave

An employee, who takes leaves because of his or her own serious health condition, shall be required to substitute all accrued paid leave, including but not limited to sick leave and vacation, for unpaid leave.

An employee who takes leave for the reason of the birth, adoption, foster care placement of a child, or for the purpose of caring for a parent, child, or spouse with a serious health condition shall be required to substitute all accrued paid leave, including up to six days of sick leave, for unpaid leave.

The employee's entitlement to unpaid leave hereunder shall run concurrently with the employee's use of paid leave. (29 U.S.C. 2612, Gov. Code 12945.2)

Maintenance of Benefits

During the period of family care or medical leave, the employee shall continue to be entitled to participate in the District health plan and the District shall continue to pay health care premiums under such plan on the same terms as if the employee had continued to work during the period of the leave. However, for any unpaid leave granted in excess of the 12 weeks of family care or medical leave in any 12-month period, the employee will be required to pay the health care premium for the remainder of the leave. Any premium payments required to be paid by the employee during such a leave must be paid at the same time as they would have been due if paid by payroll deduction, except as other arrangements are approved by the Payroll Director.

The District may recover the premium that the District paid as required by state and federal law for maintaining coverage for the employee under the group health plan if both of the following conditions occur:

1. The employee fails to return from leave after the period of leave to which the employee is entitled has expired.
2. The employee's failure to return from leave is for a reason other than the continuation, recurrence, or onset of a serious health condition that entitles the employee to leave under state or federal law or other circumstances beyond the control of the employee.

Any employee taking leave under this Administrative Regulation shall continue to be entitled to participate in retirement plans, supplemental unemployment benefit plans, and any other employee benefit plans, to the same extent and under the same conditions that apply to an unpaid leave taken for any purpose other than those described in this Administrative Regulation. In the absence of these conditions, an employee shall continue to be entitled to participate in such plans, and the District shall require the employee to pay premiums, at the group rate, during the period of time off, or any other paid or unpaid time off, as a condition of continued coverage during the leave period. However, the non-payment of premiums by an employee shall not constitute a break in service for the purpose of longevity or seniority under any collective bargaining agreement, or any employee benefit plan (Govt. Code 12945.2)

For purposes of retirement plans, the District shall not be required to make plan payments for an employee during the period of the leave, and the leave period shall not be required to be counted or purposes of time accrued under the plan. However, an employee covered by a retirement plan may continue to make contributions in accordance with the terms of the plan during the period of the leave subject to approval by STRS or PERS.

The employee shall retain his/her employee status with the District during the leave period. For purposes of layoff, recall, promotion, job assignment, and seniority-related benefits such as vacation, the employee returning from family care or medical leave shall return with no less seniority than he/she had when the leave began. (Govt. Code 12945.2)

Requests, Advance Notice, and Certifications

If an employee learns of the need for family care or medical leave more than 30 days before the leave is to begin, he/she shall give the District at least 30 days advance notice. If the employee learns of the need for family care or medical leave fewer than 30 days in advance, he/she shall provide such notice as soon as practicable. (29 U.S.C. 2612; Govt. Code 12945.2)

If leave is needed for planned medical treatment or supervision, the employee shall make a reasonable effort to schedule the treatment or supervision so as to avoid disruption of District operations. This scheduling shall be subject to the health care provider's approval. On or before the first day of an employee's family care or medical leave, the employee shall notify the District of his or her anticipated date of return to work. The District may require periodic updates on the employee's intent to return to work. If, because of changed circumstances, an employee requires more or less leave than originally anticipated, such an employee shall give the District at least two business days' notice of his or her intent to return to work. (29 U.S.C. 2612; Govt. Code 12945.2)

An employee's request for leave to care for a child, spouse, or parent who has a serious health condition shall be supported by a certification from the health care provider of the person requiring care. This certification shall include:

1. The date, if known, on which the serious health condition began.
2. The probable duration of the condition.
3. An estimate of the amount of the time the health care provider believes the employee needs to care for the eligible family member.
4. A statement that the serious health condition warrants the care of a family member to provide during a period of the treatment or supervision of the child, parent, or spouse.

As a condition of an employee's return from leave taken because of the employee's own serious health condition, the employee shall obtain certification from his or her health care provider that the employee is able to perform the essential job functions of his or her position with or without reasonable accommodation.

If additional leave is needed when the time estimated by the health care provider expires, the District may require the employee to provide recertification as specified above.

An employee's request for leave because of his/her own serious health condition shall be supported by a certification from the employee's health care provider. The certification shall include:

1. The date, if known, on which the serious health condition began.
2. The probable duration of the condition.
3. A statement that, due to the serious health condition, the employee is unable to perform the functions of his/her position. (29 U.S.C. 2613)
4. Indication if the employee is released to return to work.

If the employee is requesting leave for intermittent treatment or leave on a reduced leave schedule for planned medical treatment, the certification must also state the medical necessity for the leave, the dates on which treatment is expected to be given, the duration and frequency of the treatment and the expected duration of the leave. (29 U.S.C. 2613)

Any required medical certification shall be provided within 15 days of the District's designation of the leave as FMLA/CFRA qualifying.

In any case in which the District has reason to doubt the validity of any certification provided to support an employee's request to take leave because of the employee's own serious health condition, the District may require that the employee obtain the opinion of a second health care provider designated or approved by the District, at the expense of the District, concerning any information contained in the certification.

In any case in which the second opinion described above differs from the opinion in the original certification, the District may, at the expense of the District, require that the employee obtain the opinion of a third health care provider, designated or approved jointly by the District and the employee, concerning any information contained in the certification, which shall be final and binding on the District and the employee.

Reinstatement Non-Discrimination

Upon granting an employee's request for family care or medical leave, the District shall guarantee to reinstate the employee in the same or comparable position when the leave ends "to the extent required by law". (29 U.S.C. 2614; Govt. Code 129452.2)

Notwithstanding the preceding paragraph, the District may refuse to reinstate an employee if all of the following apply:

1. The employee is among the highest paid 10 percent of District employee's; and
2. The refusal is necessary to prevent substantial and grievous economic injury to the operations of the District; and
3. The District notifies the employee of the intent to refuse reinstatement at the time the District determines the refusal is necessary under subparagraph 2.

The District shall not refuse to hire and shall not discharge, fine, suspend, expel, or discriminate against any employee because he/she exercises his/her rights under this regulation or gives information or testimony regarding his/her or another person's family care or medical leave in an inquiry related to such leave.

Notifications

In accordance with the law, the District shall notify employees of their right to request family care and medical leave. Furthermore, in those cases where the District becomes aware that an employee has taken leave for a reason that would otherwise qualify under the FMLA, such leave shall be designated as such and the employee will be noticed accordingly.

Mt. San Antonio College

FAMILY CARE AND MEDICAL LEAVE

As an employee of Mt. San Antonio College, I certify that I have read and have received a copy of the ***Family Care and Medical Leave Procedure.***

Print Name

Date

Signature



**MT. SAN ANTONIO COLLEGE
Human Resources**

TO: Mt. San Antonio College Employees
FROM: Human Resources
SUBJECT: COLLEGE NON-DISCRIMINATION STATEMENT

Mt. San Antonio College's Non-Discrimination Statement is distributed as a reminder of our commitment to equal access to employment and educational opportunities for all persons.

NON-DISCRIMINATION STATEMENT

Mt. San Antonio College is an equal opportunity employer and is committed to an active Faculty and Staff Diversity program. It is the stated policy of Mt. San Antonio College that harassment is prohibited and that all persons shall receive equal employment and educational opportunities without regard to sex, race, color, ancestry, religious creed, national origin, age (over 40), medical condition (cancer), mental disability, physical disability (including HIV & AIDS), marital status, sexual orientation, or Veteran Status. This nondiscrimination policy covers Family and Medical Care Leave, Pregnancy Disability Leave, admission and access to, and treatment and employment in, any of the College's programs, services, or activities including vocational education.

Human Resources is responsible for Title IX, Title VI, Title VII, Americans with Disabilities Act, Section 504, and A.B. 803 compliance. The College aims to be proactive in responding to the needs of historically underrepresented groups, women, and persons with disabilities. Any person has the right to file a civil rights complaint and no person may be treated differently, or otherwise suffer retaliation, because of the exercise of this right. Policies and grievance procedures for unlawful discrimination and complaint procedures for sexual harassment for students and employees may be obtained by contacting:

Human Resources, Building 4, ext. 4225

MT. SAN ANTONIO COMMUNITY COLLEGE DISTRICT BOARD POLICY

Chapter 3 - General Institution

AP 3410 Nondiscrimination

Education Programs

References:

Education Code Sections 66250 et seq., 200 et seq., and 72010 et seq.; Accreditation Standards

The College shall provide access to its services, classes, and programs without regard to race, religious creed, color, national origin, ancestry, physical disability, mental disability, medical condition, marital status, sex (gender), age, sexual orientation, or the perception that a person has one or more of these characteristics.

All courses, including noncredit classes, shall be conducted without regard to the gender of the student enrolled in the classes.

The College shall not prohibit any student from enrolling in any class or course on the basis of gender.

Academic staff, including, but not limited to, counselors, instructors, and managers shall not offer program guidance to students which differs on the basis of gender.

Insofar as practicable, the College shall offer opportunities for participation in athletics equally to male and female students.

Employment

References:

Education Code Sections 87100 et seq.; Government Code Sections 11135 et seq. and 12940 et seq.; and Title 5 Sections 53000 et seq.

The College shall provide equal employment opportunities to all applicants and employees regardless of race, religious creed, color, national origin, ancestry, physical or mental disability, medical condition, marital status, sex (gender), age, sexual orientation, or the perception that a person has one or more of these characteristics.

All employment decisions, including, but not limited to, hiring, retention, assignment, transfer, evaluation, dismissal, compensation, and advancement for all position classifications shall be based on job-related criteria as well as be responsive to the College's needs.

All College employees are encouraged to be involved in the active promotion of diversity in employment, including recruitment.

The College shall, as necessary, provide professional and staff development activities and training to promote understanding of diversity.

Mt. San Antonio College
COLLEGE NON-DISCRIMINATION STATEMENT

I, hereby acknowledge receipt of the **College Non-Discrimination Statement** (dated 8/25/16) and the **AP 3410 Nondiscrimination** policy. Upon receiving this policy I further acknowledge that I have been provided an explanation and that I have a reasonable understanding of the policy. I also understand the rules and regulations of this policy.

Print Name

Date

Signature



HUMAN RESOURCES

DISTRICT POLICY ON DRUG FREE ENVIRONMENT

The Board of Trustees of Mt. San Antonio College District adopted a policy regarding a “Drug-Free Environment.” This Board Policy is printed on the reverse side of this memorandum. The policy prohibits illegal manufacture, distribution, dispensation, possession, use or sale of controlled substances by District employees in the workplace. Any violation of the policy may be cause for disciplinary action which may include termination or may require an employee to participate satisfactorily in a substance-abuse assistance or rehabilitation program.

Mt. San Antonio Community College District strives to maintain a drug-free environment. The College recognizes substance dependency as potentially treatable and encourages employees with substance dependency problems to contact Student Health Services or Human Resources for assistance in obtaining information about appropriate available counseling and rehabilitation services for themselves and their families.

If you have any questions about the policy or need more information, contact Student Health Services at ext. 4400 or Human Resources at ext. 4225.

**MT. SAN ANTONIO COMMUNITY COLLEGE DISTRICT
BOARD POLICY**

Chapter 3 – General Institution

BP 3550 Drug Free Environment and Drug Prevention Program

References:

Drug Free Schools and Communities Act, 20 U.S.C. Section 1145g and 34 C.F.R. Section 86.1 et seq.; Drug Free Workplace Act of 1988, 41 U.S.C. Section 702

The College shall be free from all illegal drugs and from the unlawful possession, use or distribution of illegal drugs and alcohol by students and employees.

The unlawful manufacture, distribution, dispensing, possession or use of alcohol or any controlled substance is prohibited on College property; in any facility operated by the College; during College-sponsored field trips, activities, or workshops; and in any College owned vehicle.

All employees are required to comply with this policy as a condition of their employment and continued employment.

Any student or employee who violates this policy will be subject to disciplinary action, which may include referral to an appropriate rehabilitation program, suspension, demotion, expulsion or dismissal. Any employee convicted under a criminal drug and/or alcohol statute for conduct in the workplace must report this conviction within five days to the College President/CEO.

The College President/CEO shall assure that the College distributes annually to each student the information required by the Drug-Free Schools and Communities Act Amendments of 1989 and complies with other requirements of the Act.

Approved April 28, 2004

Mt. San Antonio College
COLLEGE DRUG FREE POLICY

I, hereby acknowledge receipt of the **College Drug Free Policy** and the **BP 3550 Drug Free Environment and Drug Prevention Program** policy. Upon receiving this policy I further acknowledge that I have been provided an explanation and that I have a reasonable understanding of the policy. I also understand the rules and regulations of this policy.

Print Name

Date

Signature



HUMAN RESOURCES

REASONABLE ACCOMMODATION INFORMATION

It is the policy of the Mt. San Antonio Community College District to make reasonable accommodation to the known physical or mental limitations of an otherwise qualified employee or applicant who has a qualifying disability unless the hiring authority can demonstrate that the accommodation would impose an undue hardship on the operation of its program. A department shall not deny any employment opportunity to a qualified employee or applicant who is an individual with a disability if the basis for the denial is the need to make reasonable accommodation to the physical or mental limitations of the applicant or employee.

QUALIFYING DISABILITY

A qualifying disability is a physical or mental disability or medical condition that limits one or more major life activities. The following are not considered disabilities under California State law: sexual behavior disorders, compulsive gambling, kleptomania, pyromania, or psychoactive substance use disorders resulting from the current unlawful use of controlled substances or other drugs.

REQUESTING ACCOMMODATION FOR DISTRICT EXAMINATIONS

When applying for a District examination, you must indicate the type of reasonable accommodation needed on your State application form. State agencies are required to respond to your request within 10 working days after the final filing date and before the date of administering the examination. If you have not received a response to your request by the time you receive a notice to appear for an examination, contact the appropriate testing office indicated on the examination bulletin.

REQUESTING ACCOMMODATION ON THE JOB

As an employee, you may request a reasonable accommodation verbally, or in writing. Examples of accommodation may include, but not be limited to:

- Job restructuring and/or reassignment
- Modified work schedule
- Reader or interpreter
- Tools, equipment, devices, furnishings

You may be required to fill out additional forms and/or provide documentation if requested by your employer. Your employer must respond within 20 calendar days of receiving the required documents pertaining to your request. If you do not receive a response, you should contact your human resources office regarding the status of your request.

Mt. San Antonio College

REASONABLE ACCOMMODATION

As an employee of Mt. San Antonio College, I certify that I have read and have received a copy of ***Reasonable Accommodation Information***.

Print Name

Date

Signature



SEXUAL HARASSMENT INCLUDES MANY FORMS OF OFFENSIVE BEHAVIORS

BEHAVIORS THAT MAY BE SEXUAL HARASSMENT:

- 1 *Unwanted sexual advances*
- 2 *Offering employment benefits in exchange for sexual favors*
- 3 *Leering; gestures; or displaying sexually suggestive objects, pictures, cartoons, or posters*
- 4 *Derogatory comments, epithets, slurs, or jokes*
- 5 *Graphic comments, sexually degrading words, or suggestive or obscene messages or invitations*
- 6 *Physical touching or assault, as well as impeding or blocking movements*

Actual or threatened retaliation for rejecting advances or complaining about harassment is also unlawful.

Employees or job applicants who believe that they have been sexually harassed or retaliated against may file a complaint of discrimination with DFEH within one year of the last act of harassment or retaliation. DFEH serves as a neutral fact-finder and attempts to help the parties voluntarily resolve disputes. If DFEH finds sufficient evidence to establish that discrimination occurred and settlement efforts fail, the Department may file a civil complaint in state or federal court to address the causes of the discrimination and on behalf of the complaining party. DFEH may seek court orders changing the employer's policies and practices, punitive damages, and attorney's fees and costs if it prevails in litigation. Employees can also pursue the matter through a private lawsuit in civil court after a complaint has been filed with DFEH and a Right-to-Sue Notice has been issued.

THE MISSION OF THE DEPARTMENT OF FAIR EMPLOYMENT AND HOUSING IS TO PROTECT THE PEOPLE OF CALIFORNIA FROM UNLAWFUL DISCRIMINATION IN EMPLOYMENT, HOUSING AND PUBLIC ACCOMMODATIONS, AND FROM THE PERPETRATION OF ACTS OF HATE VIOLENCE AND HUMAN TRAFFICKING.

FOR MORE INFORMATION

Department of Fair Employment and Housing
Toll Free: (800) 884-1684
TTY: (800) 700-2320
Online: www.dfeh.ca.gov

Also find us on:



If you have a disability that prevents you from submitting a written pre-complaint form on-line, by mail, or email, the DFEH can assist you by scribing your pre-complaint by phone or, for individuals who are Deaf or Hard of Hearing or have speech disabilities, through the California Relay Service (711), or call us through your VRS at (800) 884-1684 (voice).

To schedule an appointment, contact the Communication Center at (800) 884-1684 (voice or via relay operator 711) or (800) 700-2320 (TTY) or by email at contact.center@dfeh.ca.gov.

The DFEH is committed to providing access to our materials in an alternative format as a reasonable accommodation for people with disabilities when requested.

Contact the DFEH at (800) 884-1684 (voice or via relay operator 711), TTY (800) 700-2320, or contact.center@dfeh.ca.gov to discuss your preferred format to access our materials or webpages.

SEXUAL HARASSMENT

THE FACTS

Sexual harassment is a form of discrimination based on sex/gender (including pregnancy, childbirth, or related medical conditions), gender identity, gender expression, or sexual orientation. Individuals of any gender can be the target of sexual harassment. Unlawful sexual harassment does not have to be motivated by sexual desire. Sexual harassment may involve harassment of a person of the same gender as the harasser, regardless of either person's sexual orientation or gender identity.

THERE ARE TWO TYPES OF SEXUAL HARASSMENT

- ① *“Quid pro quo”* (Latin for “this for that”) sexual harassment is when someone conditions a job, promotion, or other work benefit on your submission to sexual advances or other conduct based on sex.
- ② *“Hostile work environment”* sexual harassment occurs when unwelcome comments or conduct based on sex unreasonably interfere with your work performance or create an intimidating, hostile, or offensive work environment. You may experience sexual harassment even if the offensive conduct was not aimed directly at you.

The harassment must be severe or pervasive to be unlawful. That means that it alters the conditions of your employment and creates an abusive work environment. A single act of harassment may be sufficiently severe to be unlawful.

CIVIL REMEDIES:



ALL EMPLOYERS MUST TAKE THE FOLLOWING ACTIONS TO PREVENT HARASSMENT AND CORRECT IT WHEN IT OCCURS:

- 1 *Damages for emotional distress from each employer or person in violation of the law*
- 2 *Hiring or reinstatement*
- 3 *Back pay or promotion*
- 4 *Changes in the policies or practices of the employer*

EMPLOYER RESPONSIBILITY & LIABILITY

All employers, regardless of the number of employees, are covered by the harassment provisions of California law. Employers are liable for harassment by their supervisors or agents. All harassers, including both supervisory and non-supervisory personnel, may be held personally liable for harassment or for aiding and abetting harassment. The law requires employers to take reasonable steps to prevent harassment. If an employer fails to take such steps, that employer can be held liable for the harassment. In addition, an employer may be liable for the harassment by a non-employee (for example, a client or customer) of an employee, applicant, or person providing services for the employer. An employer will only be liable for this form of harassment if it knew or should have known of the harassment, and failed to take immediate and appropriate corrective action.

Employers have an affirmative duty to take reasonable steps to prevent and promptly correct discriminatory and harassing conduct, and to create a workplace free of harassment.

A program to eliminate sexual harassment from the workplace is not only required by law, but it is the most practical way for an employer to avoid or limit liability if harassment occurs.

- ① Distribute copies of this brochure or an alternative writing that complies with Government Code 12950. This pamphlet may be duplicated in any quantity.
- ② Post a copy of the Department's employment poster entitled "California Law Prohibits Workplace Discrimination and Harassment."
- ③ Develop a harassment, discrimination, and retaliation prevention policy in accordance with 2 CCR 11023. The policy must:
 - Be in writing.
 - List all protected groups under the FEHA.
 - Indicate that the law prohibits coworkers and third parties, as well as supervisors and managers with whom the employee comes into contact, from engaging in prohibited harassment.
 - Create a complaint process that ensures confidentiality to the extent possible; a timely response; an impartial and timely investigation by qualified personnel; documentation and tracking for reasonable progress; appropriate options for remedial actions and resolutions; and timely closures.
 - Provide a complaint mechanism that does not require an employee to complain directly to their immediate supervisor. That complaint mechanism must include, but is not limited to including: provisions for direct communication, either orally or in writing, with a designated company representative; and/or a complaint hotline; and/or access to an ombudsperson; and/or identification of DFEH and the United States Equal Employment Opportunity Commission as additional avenues for employees to lodge complaints.
 - Instruct supervisors to report any complaints of misconduct to a designated company representative, such as a human resources

manager, so that the company can try to resolve the claim internally. Employers with 50 or more employees are required to include this as a topic in mandated sexual harassment prevention training (see 2 CCR 11024).

- Indicate that when the employer receives allegations of misconduct, it will conduct a fair, timely, and thorough investigation that provides all parties appropriate due process and reaches reasonable conclusions based on the evidence collected.
 - Make clear that employees shall not be retaliated against as a result of making a complaint or participating in an investigation.
- ④ Distribute its harassment, discrimination, and retaliation prevention policy by doing one or more of the following:
 - Printing the policy and providing a copy to employees with an acknowledgement form for employees to sign and return.
 - Sending the policy via email with an acknowledgment return form.
 - Posting the current version of the policy on a company intranet with a tracking system to ensure all employees have read and acknowledged receipt of the policy.
 - Discussing policies upon hire and/or during a new hire orientation session.
 - Using any other method that ensures employees received and understand the policy.
 - ⑤ If the employer's workforce at any facility or establishment contains ten percent or more of persons who speak a language other than English as their spoken language, that employer shall translate the harassment, discrimination, and retaliation policy into every language spoken by at least ten percent of the workforce.
 - ⑥ In addition, employers who do business in California and employ 50 or more part-time or full-time employees must provide at least two hours of sexual harassment training every two years to each supervisory employee and to all new supervisory employees within six months of their assumption of a supervisory position.

**MT. SAN ANTONIO COMMUNITY COLLEGE DISTRICT
BOARD POLICY**

Chapter 3 – General Institution

BP 3430 Prohibition of Harassment

References:

Education Code Sections 212.5; 44100, 66252; 66281.5; Government Code Section 12950.1; Title VII of the Civil Rights Act of 1964, 42 U.S.C.A. § 2000e.

All forms of harassment are contrary to basic standards of conduct between individuals and are prohibited by State and federal law, as well as this policy, and will not be tolerated. The College is committed to providing an academic and work environment that respects the dignity of individuals and groups. The College shall be free of sexual harassment and all forms of sexual intimidation and exploitation including acts of sexual violence. It shall also be free of other unlawful harassment including that which is based on any of the following statuses: race, religious creed, color, national origin, ancestry, physical disability, mental disability, mental condition, genetic information, marital status, sex, gender, gender identity, gender expression, age, or sexual orientation, military status, or veteran status of any person, or because he or she is perceived to have one or more of the foregoing characteristics.

Any student or employee who believes that he or she has been harassed or retaliated against in violation of this policy should immediately report such incidents by following the procedures delineated in the Administrative Procedures. Supervisors are mandated to report all incidents of harassment and retaliation that come to their attention.

The College seeks to foster an environment in which all employees and students feel free to report incidents of harassment without fear of retaliation or reprisal. Therefore, the College also strictly prohibits retaliation against any individual for filing a complaint of harassment or for participating in a harassment investigation. Such conduct is illegal and constitutes a violation of this policy. All allegations of retaliation will be swiftly and thoroughly investigated. If the College determines that retaliation has occurred, it will take all reasonable steps within its power to stop such conduct. Individuals who engage in retaliatory conduct are subject to disciplinary action, up to and including termination or expulsion.

This policy applies to all aspects of the academic environment including, but not limited to, classroom conditions, grades, academic standing, employment opportunities, scholarships, recommendations, disciplinary actions, and participation in any community college activity. In addition, this policy applies to all terms and conditions of employment including, but not limited to, hiring, placement, promotion, disciplinary action, layoff, recall, transfer, leave of absence, training opportunities, and compensation.

To this end, the College President/CEO shall ensure that the institution undertakes education activities and training to counter discrimination and to prevent, minimize, and/or eliminate any hostile environment that impairs access to equal education opportunity or impacts the terms and conditions of employment.

The College President/CEO shall establish procedures that define harassment on campus. The College President/CEO shall further establish procedures for employees, students, and other members of the campus community that provide for the investigation and resolution of complaints regarding harassment and discrimination, and procedures for students to resolve complaints of harassment and discrimination. All participants are protected from retaliatory acts by the College, its employees, students, and agents.

This policy and related written procedures including the procedure for making complaints shall be widely published and publicized to administrators, faculty, staff, and students, particularly when they are new to the institution. They shall be available for students and employees in all administrative offices.

Employees who violate the policy and procedures may be subject to disciplinary action up to and including termination. Students who violate this policy and related procedures may be subject to disciplinary measures up to and including expulsion.

Approved: April 28, 2004

Revised: April 20, 2005

Revised: February 27, 2013

Revised: December 10, 2014

Mt. San Antonio College

SEXUAL HARASSMENT POLICY

I, hereby acknowledge receipt of the ***Sexual Harassment DFEH*** pamphlet and the ***BP 3430 Prohibiting Sexual Harassment*** policy. Upon receiving this policy, I further acknowledge that I have been provided an explanation and that I have a reasonable understanding of the policy. I also understand the rules and regulations of this policy.

Print Name

Date

Signature

Chapter 3 - General Institution

AP 3720 Use of Technology and Information Resources and Employee Acceptable Use Agreement

References:

Education Code Section 70902; 17 U.S.C. § 101 et seq. (Copyright Act); Penal Code Section 502; Academic Senate for California Community Colleges 1999 paper *Academic Freedom, Privacy, Copyright and Fair Use in a Technological World*

The College technology systems and tools are the sole property of Mt. San Antonio College. They may not be used by any person without the proper authorization of the College. The technology systems and tools are for College instructional and work related purposes.

This procedure applies to all Mt. San Antonio College students, faculty, and staff and to others granted use of College information resources. This procedure refers to all College information resources whether individually controlled or shared, stand-alone, or networked. It applies to all computer and computer communication facilities owned, leased, operated, or contracted by the College. This includes personal computers, workstations, associated peripherals and software, and information resources, regardless of whether used for administration, research, teaching or other purposes.

Conditions of Use:

Individual units within the College may define additional conditions of use for information resources under their control. These statements must be consistent with this overall procedure but may provide additional detail, guidelines and/or restrictions. Employees must also consider the open nature of information transferred electronically and should not assume an absolute guarantee of privacy or restricted access to such information. Mt. San Antonio College reserves the right to monitor all use of the College network and computer to assure compliance with appropriate policies. Mt. San Antonio College will exercise this right only for legitimate College purposes, including, but not limited to, ensuring compliance with this procedure and the integrity and security of the system.

The College supports and endorses the fundamental principles and the right of freedom of expression and endeavors to insure appropriate confidentiality of communication. Nevertheless, all users should be aware that they have no guarantee of privacy or security when using College technology systems and tools. The College strives to provide the highest degree of privacy and security possible when transferring data but disclaims responsibility if security measures are circumvented and the information is compromised.

Legal Process:

This procedure exists within the framework of the College Board Policy and State and federal laws. A user of College information resources who is found in violation of the College's computer use policies is subject to proper disciplinary action, including the reporting of such activity to the appropriate authorities as required by law, up to and including but not limited to

loss of information resources privileges; disciplinary suspension or termination from employment or expulsion; and/or civil or criminal legal action (see Appendix A: Selected Examples of Unacceptable Use).

Users of College technology systems and tools should also be aware of items such as the following:

- **Possibility of Disclosure** - Users must be aware of the possibility of unintended disclosure of communications.
- **Retrieval** - It is possible for information entered on or transmitted via computer and communications systems to be retrieved, even if a user has deleted such information.
- **Public Records** - The California Public Records Act (Government Code Sections 6250 et seq.) includes computer transmissions in the definition of “public record” and nonexempt communications made on the College network and computer must be disclosed if requested by a member of the public.
- **Litigation** - Computer transmissions may be discoverable in litigation.

Copyrights and Licenses:

Computer users must respect copyrights and licenses to software and other on-line information.

- **Copying** - Software protected by copyright may not be copied except as expressly permitted by the owner of the copyright or otherwise permitted by copyright law. Protected software may not be copied into, from, or by any College facility or system, except pursuant to a valid license or as otherwise permitted by copyright law.
- **Number of Simultaneous Users** - The number and distribution of copies must be handled in such a way that the number of simultaneous users in a department does not exceed the number of original copies purchased by that department, unless otherwise stipulated in the purchase contract.
 - **Copyrights** - In addition to software, all other copyrighted information (text, images, icons, programs, etc.) retrieved from computer or network resources, including the Internet, must be used in conformance with applicable copyright and other laws. Work deemed protected under Section 107 of the Copyright Act of 1976 (“Fair Use”) shall be documented as having satisfied the four factor test.

Integrity of Information Resources:

Computer users must respect the integrity of computer-based information resources.

- **Modification or Removal of Equipment** - Computer users must not attempt to modify or remove computer equipment, software, or peripherals that are owned by others without proper authorization.

- Unauthorized Use - Computer users must not interfere with others access and use of the College computers. This includes, but is not limited to: the sending of ~~chain letters~~ or excessive messages, either locally or off-campus; printing excess copies of documents, files, data, or programs; running grossly inefficient programs when efficient alternatives are known by the user to be available; unauthorized modification of system facilities, operating systems, or disk partitions; attempting to crash or tie up a College computer or network; installing or connecting unauthorized equipment; and damaging or vandalizing College computing facilities, equipment, software, or computer files.
- Unauthorized Programs - Computer users must not intentionally develop or use programs which disrupt other computer users or which access private or restricted portions of the system, or which damage the software or hardware components of the system. Computer users must ensure that they do not use programs or utilities that interfere with other computer users or that modify normally protected or restricted portions of the system or user accounts. The use of any unauthorized or destructive program will result in disciplinary action as provided in this procedure, and may further lead to civil or criminal legal proceedings.

Unauthorized Access:

Computer users must not seek to gain unauthorized access to information resources and must not assist any other persons to gain unauthorized access.

- Abuse of Computing Privileges - Users of College information resources must not access computers, computer software, computer data or information, or networks without proper authorization, or intentionally enable others to do so, regardless of whether the computer, software, data, information, or network in question is owned by the College.
- Reporting Problems - Any defects discovered in system accounting or system security must be reported promptly to the appropriate system manager so that steps can be taken to investigate and solve the problem.
- Password Protection - A computer user who has been authorized to use a password-protected account may be subject to both civil and criminal liability if the user discloses the password or otherwise makes the account available to others without permission of the Chief Technology Officer or designee.

Usage:

Computer users must respect the rights of other computer users. Attempts to circumvent these mechanisms in order to gain unauthorized access to the system or to another person's information are a violation of College procedure and may violate applicable law. The College is a non-profit, tax-exempt organization and, as such, is subject to specific federal, State and local laws regarding sources of income, political activities, use of property, and similar matters.

- Unlawful Messages - Users may not use electronic communication facilities to send defamatory, fraudulent, harassing, obscene, threatening, or other messages that violate applicable federal, State or other law or College policy, or which constitute the unauthorized release of confidential information.
- Commercial Usage - Electronic communication facilities must not be used to transmit commercial or personal advertisements, solicitations or promotions. Some public discussion groups have been designated for selling items and may be used appropriately, according to the stated purpose of the group(s). College information resources should not be used for commercial purposes. Users also are reminded that the “.cc” and “.edu” domains on the Internet have rules restricting or prohibiting commercial use, and users may not conduct activities not appropriately within those domains.
- Information Belonging to Others - Users must not intentionally seek or provide information on, obtain copies of, or modify data files, programs, or passwords belonging to other users, without the permission of those other users.
- User Identification & Rights of Individuals - Users shall not send communications or messages anonymously or without accurately identifying the originating account or station. Users must not release any individual’s (student, faculty, and staff) personal information to anyone without proper authorization from the individual affected.
- Political Use - College information resources must not be used for partisan political activities where prohibited by federal, State or other applicable laws.
 - Personal Use - College information resources should not be used for personal activities not related to appropriate College functions, except in a purely incidental manner so long as: (a) it does not consume more than a trivial amount of system resources; (b) it does not interfere with the productivity of other campus employees, and (c) it does not preempt any College activity.
 - Captioning/Closed Captioning – All video media posted to the College affiliated Internet or Intranet must be captioned or sub-titled for the deaf or hard of hearing. Any exceptions must be approved by a section 504 compliance officer.
 - Remote Access – Remote access to sensitive College systems is provided by Virtual Private Network (VPN) based on critical business need. VPN access may be requested by completing the VPN request form and obtaining the appropriate approval signatures. Request for VPN access must be approved by the Chief Technology Officer. Mt. SAC reserves the right to audit all VPN client systems and all communications between VPN client systems and Mt. SAC’s network for compliance with all applicable security requirements.

Electronic Communication (email):

All Mt. San Antonio College related email communications must be conducted using an email address assigned by the College. This restriction is necessary because email originating at the College may contain proprietary information regarding students, staff, or internal College business. The College is responsible for the security of this information and cannot assume

that other email providers will provide adequate levels of data backup, security, and virus protection. Users may not configure any email program or service to use an automated process for forwarding Mt. San Antonio College email to any other email address.

Social Media Definition:

Social networking includes networking sites that communicate via the Internet and networking sites that use SMS text or mobile technologies. All genres of social networking sites or media will be referred to below as social media. Currently popular examples of social media include Facebook, Twitter and similar utilities, sites, and/or resources.

Social Media Responsibility:

College employees are responsible for the content they post to social media. The College will neither indemnify employees for anything they write on social media nor restrict employee speech on social media not associated with the college. Social media officially affiliated with the College or used by employees to enhance instruction is subject to the following procedures:

- College Coursework - Faculty utilizing social media to enhance instruction must accept responsibility as the site administrator for said media.
- College Departments - Social media for a College department requires prior approval from the department administrator. An email or written proposal or approval will suffice. Social media for College departments will have a minimum of two site administrators assigned. If a site administrator leaves the College, the department administrator will assign another in their place and the account password will be changed.
- College Clubs and Organizations - Social media for college clubs and organizations cannot be affiliated with the College without prior approval from the College club sponsor/advisor or other college employee. Social media for college clubs and organizations should have two site administrators of which at least one is a College employee. Those site administrators can optionally authorize and assign student site administrator(s), and revoke those privileges if the student site administrator(s) is not acting in accordance with these procedures.

The site administrator(s) shall post their name(s) and a contact method prominently on the site and shall check their pages regularly for prohibited content. Examples of content prohibited from social media officially affiliated with Mt. SAC and, if possible, should be removed by the site administrator upon discovery, are:

- Derogatory language that can reasonably be interpreted as harassing or threatening any third party
- Language or images encouraging or depicting sexual harassment, vandalism, stalking, drinking, drug use, criminal activity, or other behavior prohibited by the Student Standards of Conduct

- Content that violates State or federal law, including online gambling and the use (without documented, written permission) of copyrighted material
- Information that is obviously libelous
- Pornography or patently obscene material as defined by law

Nondiscrimination:

All users have the right to be free from any conduct connected with the use of the Mt. San Antonio College network and computer resources which discriminates against any person on the basis of BP 3410. No user shall use the College network and computer resources to transmit any message, create any communication of any kind, or store information which violates any College procedure regarding discrimination or harassment, or which is defamatory or obscene, or which constitutes the unauthorized release of confidential information.

Appendix A: Selected Examples of Unacceptable Use:

- Revealing passwords to others, or allowing someone else to use one's account.
- Utilizing network or system id numbers/names that are not assigned for one's specific use on the designated system.
- Attempting to authorize, delete, or alter files or systems not created by oneself without authorization from the Chief Technology Officer or his/her designee.
- Not complying with requests from designated personnel to discontinue activities that threaten the integrity of computing resources.
- Attempting to defeat data protection schemes or to uncover security vulnerabilities.
- Registering a Mt. San Antonio College IP address with any other domain name.
- Unauthorized network scanning or attempts to intercept network traffic *including the use of unauthorized wireless Access Points or similar devices*.
- Malicious disruptions such as intentionally introducing a computer virus to the campus network.
- Harassing or threatening other users of the campus network.
- Connecting unauthorized equipment directly to the campus network. (Devices such as PDAs, printers, and USB drives that connect to a computer and not directly to the network are acceptable.)

Signature Page: Dissemination and User Acknowledgment:

All users shall be provided copies of AP 3720 and shall be responsible for adhering to its content. Signed agreement is required by all employees to receive system access accounts and utilize the College technology systems and tools.

The provisions and terms of AP 3720 constitute an agreement between the College and employee as to their agreed upon rights and duties as such relate to the utilization of the College technology systems and tools. These terms are subject to change only upon mutual written agreement between the College and the respective constituent groups. The College shall make the current version of this document available at <http://infosecurity.mtsac.edu>. All Parties are put on notice that a violation of the above terms and provisions may result in civil, criminal, or other administrative action, including the reporting of such activity to the appropriate authorities as required by law, up to and including but not limited to loss of information resources privileges; disciplinary suspension or termination from employment or expulsion; and/or civil or criminal legal action.

As an employee of Mt. San Antonio College, I certify that I have read and have received a copy of this agreement (AP 3720).

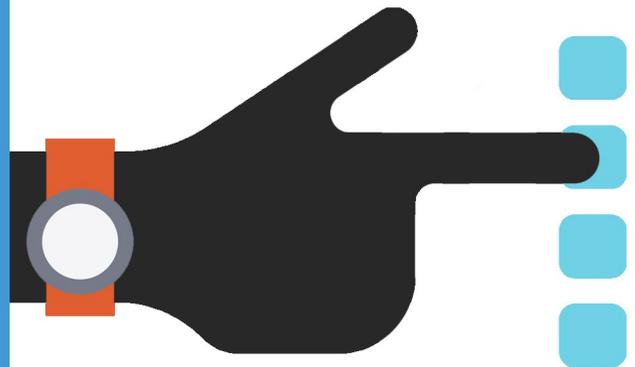
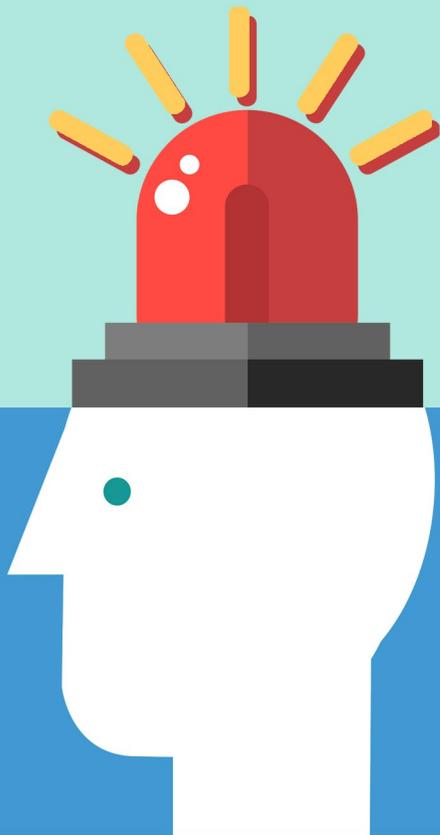
Name: _____
Print Name

Name: _____ Date: _____
Signature

What Will You Do?



Emergency Response Quick Reference Guide



Police & Campus Safety: (909) 274-4555

EXIT

EVACUATION

- Stay calm. Do not rush or panic.
- Use the stairs. Do not use the elevator.
- Assist others if possible. Once you are out of the building go to the nearest Evacuation Assembly area (*See back panels*).
- Wait for instructions and additional information from Police & Campus Safety OR emergency responders.



EARTHQUAKE

- Take immediate shelter under tables, desks, or other furniture. (Remember to **drop, cover** and **hold on**.)
- If it unsafe to remain inside, evacuate (*See EVACUATION*) the building when safe to do so, assisting others if possible. Immediately inform emergency responders if injured or disabled need assistance.
- Assist others if possible, once you are out of the building, go to the nearest Evacuation Assembly Area (*See back panels*)
- Wait for instructions and additional information from Police & Campus Safety or emergency responders.



CRIMINAL ACTIVITY

- Call Campus Safety at ext. 4555 and report the type and location of activity (crime, assault, theft, etc.) from a safe location.
- Do not attempt to apprehend the person(s) involved.



FIRE

- **Evacuate building** (*See EVACUATION*) and assist others if possible. Inform emergency responders if injured or disabled need assistance.
- Do not ignore fire alarms. Evacuate using the safest route.
- If you see a fire, activate the nearest fire alarm box if it is safe to do so.
- Call the Police & Campus Safety at ext. 4555 and report the location of the fire.



UTILITY FAILURE

- **Remain indoors** if there is natural light and if it is safe to do so. Power may resume within minutes.
- Check the Mt. SAC website or look for a Mt. SAC emergency notification to provide additional information.
- Follow directions provided by campus and emergency response teams.
- Contact Police & Campus Safety if special assistance is needed.



SUSPICIOUS PACKAGE OR BOMB THREAT

- **Call Police & Campus Safety at ext. 4555 immediately** to report a suspicious package.
- Check the Mt. SAC website or look for a Mt. SAC emergency notification to provide additional information.
- Follow directions provided by campus and emergency response teams.



ACTIVE SHOOTER

- Remember: **Run, Hide, Be Prepared to Fight.**
- If you suspect gunfire, don't wait for others to confirm it – Leave the area as quickly as possible. **Call Police & Campus Safety at ext. 4555** and report the type and location of the shooter from a safe location.
- Hide if you cannot escape.
- Barricade doors (use chairs, cabinets, furniture), turn off lights, and silence your cellphone.

For additional information visit www.mtsac.edu/emergency



CALL POLICE & CAMPUS SAFETY (909) 274-4555 TO:

- **report suspicious activity.**
- **report a hazardous condition person(s) involved.**
- **report a spill or leak that may be a safety issue.**
- **request an escort to your car.**

Where Will I Go?

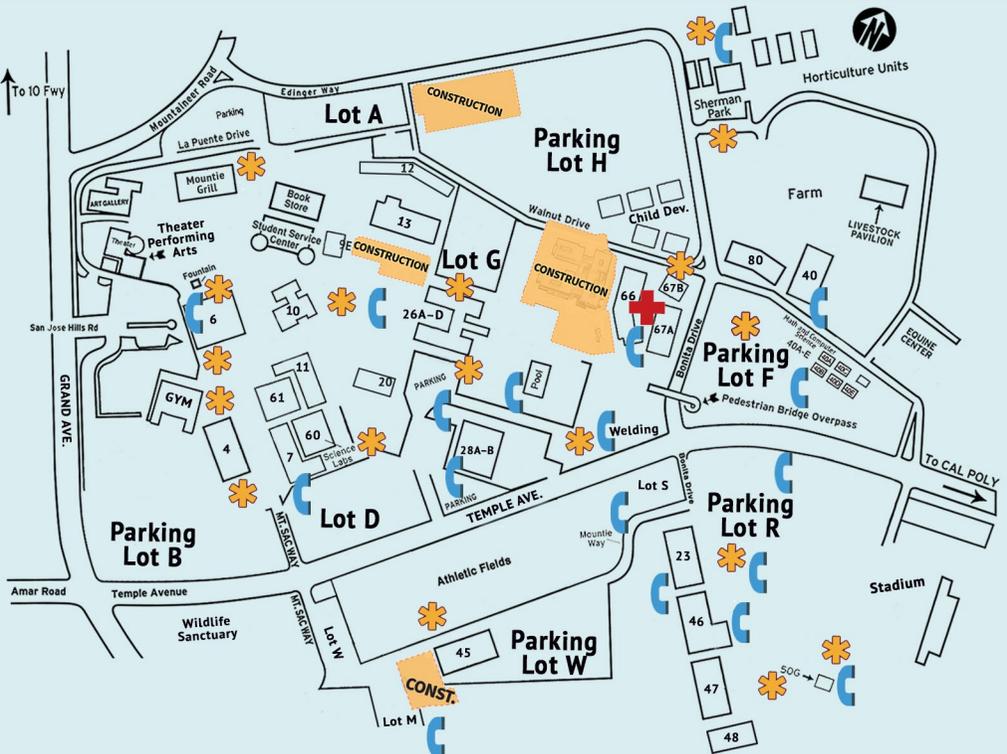
If you must evacuate, report to the **nearest** evacuation assembly site to your office or location.

✿ – Evacuation Areas + – First Aid / Triage ☒ – Emergency Blue Phones



POLICE & CAMPUS SAFETY (909) 274-4555

For a detailed evacuation areas map, go to: www.mtsac.edu/maps



What Should You Do?

This brochure is a quick reference guide for Mt. SAC emergency procedures. The complete Emergency Procedures document is available on the Mt. SAC portal.

This brochure will tell you what to do and where to go during an emergency. Please keep it on hand as a quick reference. We also encourage you to consult the complete plan for more detailed information and sign up for **Mt. SAC Alerts** (on the portal) for emergency notifications.

Your Safety Should Be Your First Priority

Want To Know More About Emergency Services?

For more information, contact
Emergency Services at
(909) 274-5567
or visit www.mtsac.edu/emergency



To report a situation or
emergency, call
Police & Campus Safety at
(909) 274-4555



1100 N. Grand Ave.
Walnut, CA 91789

Mt. SAC Employee Disaster Service Workers

As a California city, county, or state agency or public district employee, you may be called upon as a disaster service workers in the event of an emergency. The information contained in this pamphlet will help you understand your role and obligation.

Public Employee Disaster Service Worker Status

It is hereby declared that the protection of the health and safety and preservation of the lives and property of the people of the state from the effects of natural, man-made, or war-caused emergencies which result in conditions of disaster or extreme peril to life, property, and resources is of paramount state importance...in protection of its citizens and resources, all public employees are hereby declared to be disaster service workers...

All disaster service workers shall, before they enter upon the duties of their employment, take and subscribe to the oath or affirmation...

What does disaster service mean?

Disaster service means all activities authorized by and carried out pursuant to the California Emergency Services Act*.

Who is included in the disaster service worker status?

All public employees are included in the disaster service worker status which are all persons employed by any county, city, state agency or public district.

What are the scope of duties of employee disaster service workers?

Any public employees performing duties as a disaster service worker shall be considered to be acting within the scope of disaster service duties while assisting any unit of the organization or performing any act contributing to the protection of life or property or mitigating the effects of an emergency.

How public employees are assigned disaster service activities?

Public employees are assigned disaster service activities by their superiors or by law to assist the agency in carrying out its responsibilities during times of disaster. Assignments may closely resemble your current job duties, such as answering phones, delivering/dispensing supplies, managing volunteers, delivering messages, and tracking information. Other duties will be based on your training or ability to perform the task. Those DSWs with emergency response training may assist or be part of a campus response teams.

What is the oath or affirmation referred to in the government code?

Before entering upon the duties of employment, all public employees take and subscribe to the oath or affirmation set forth in the California Constitution that declares them to be disaster service workers in time of need.

When do public employees take the oath or affirmation?

Most public employees sign the oath or affirmation during the hiring process and it is kept with the employer.

Do public employees acting as disaster service workers get paid?

Public employees acting as disaster service workers get paid only if they have taken and subscribed to the oath or affirmation.

Can disaster service workers be sued for actions taken while performing duties?

Public employee disaster service workers for non-profit organizations and government cannot be held liable for their actions during a disaster while acting within the scope of their responsibilities.



What if public employees are injured while acting as disaster service workers?

Claims sustained by public employees while performing disaster services shall be filed as worker compensation claims under the same authorities and guidelines as with all employees within their agency.

How will I know if I am needed as a Disaster Service Worker?

All campus staff and students are encouraged to sign up in the Mt. SAC portal to receive Emergency Alert Notifications. Depending on the incident circumstances, Mt. SAC Disaster Service Workers will receive instructions via the Emergency Alert Notification System. DSWs may also be notified they are needed by their supervisors.

What if I cannot stay to assist or must leave campus during an emergency?

All campus staff are encouraged to be prepared for emergencies or disasters at home, on the road and at work. Personal preparedness and response plans and supplies are a must. If you must leave campus be sure to notify your supervisor. If you cannot contact your supervisor, call the Mt. SAC Disaster Service Worker hotline at (909) 274 - 5688 and follow the reporting instructions. Be patient, the phone lines may be busy.

For more information, please visit the following websites:

California Emergency Services Act
<http://bit.ly/CalEmServAct>

California Government Code 3100-3109
<http://bit.ly/CalGovC3100>

The California Constitution oath or Affirmation
<http://bit.ly/CalConsOath>

Governor's Office of Emergency Services
<http://bit.ly/GOESPlanPrepDoc2016>
(see page 10, "Dsw Public Employees")

Mt SAC Emergency Preparedness
<http://www.mtsac.edu/emergency>

Ready.Gov
www.ready.gov

American Red Cross Emergency Preparedness
<http://www.redcross.org/get-help/how-to-prepare-for-emergencies>





Important Information about Medical Care if you have a Work-Related Injury or Illness

Complete Written Employee Notification regarding Medical Provider Network
(Title 8, California Code of Regulations, Section 9767.12)

California law requires your employer to provide and pay for medical treatment if you are injured at work. Your employer has chosen to provide this medical care by using a Workers' Compensation physician network called a Medical Provider Network (MPN). This MPN is administered by Harbor Health Systems. This notification tells you what you need to know about the MPN program and describes your rights in choosing medical care for work-related injuries and illnesses.

What happens if I get injured at work?

In case of an emergency, you should call 911 or go to the closest emergency room.

If you are injured at work, notify your employer as soon as possible. Your employer will provide you with a claim form. When you notify your employer that you have had a work-related injury, your employer or insurer will make an initial appointment with a doctor in the MPN.

What is an MPN?

A Medical Provider Network (MPN) is a group of health care providers (physicians and other medical providers) used by YOUR EMPLOYER to treat workers injured on the job. MPNs must allow employees to have a choice of provider(s). Each MPN must include a mix of doctors specializing in work-related injuries and doctors with expertise in general areas of medicine. □ **What MPN is used by my employer?**

Your employer is using the PRIME Advantage MPN Powered by Harbor Health Systems MPN with the identification number 2358. You must refer to the MPN name and the MPN identification number whenever you have questions or requests about the MPN.

Who can I contact if I have questions about my MPN?

The MPN Contact listed in this notification will be able to answer your questions about the use of the MPN and will address any complaints regarding the MPN.

The contact for your MPN is:

Name: Harbor Health Systems MPN Contact
Title: MPN Contact
Address: PO Box 54770, Irvine, CA 92619-4770 Telephone
Number: (888) 626-1737
Email address: MPNcontact@hARBORSYS.COM

General information regarding the MPN can also be found at the following website: www.hARBORSYS.COM/Keenan

What if I need help finding and making an appointment with a doctor?

The MPN's Medical Access Assistant will help you find available MPN physicians of your choice and can assist you with scheduling and confirming physician appointments. The Medical Access Assistant is available to assist you Monday through Saturday from 7am-8pm (Pacific) and schedule medical appointments during doctors' normal business hours. Assistance is available in English and in Spanish.

The contact information for the Medical Access Assistant is:

Toll Free Telephone Number: (855) 521-7080
Fax Number: (703) 673-0181
Email Address: MPNMAA@hARBORSYS.COM

How do I find out which doctors are in my MPN?

You can get a regional list of all MPN providers in your area by calling the MPN Contact or by going to our website at: www.harborsys.com/Keenan. At minimum, the regional list must include a list of all MPN providers within 15 miles of your workplace and/or residence or a list of all MPN providers within the county where you live and/or work. You may choose which list you wish to receive. You also have the right to obtain a list of all the MPN providers upon request. You can access the roster of all treating physicians in the MPN by going to the website at www.harborsys.com/Keenan.

How do I choose a provider?

Your employer or the insurer for your employer will arrange the initial medical evaluation with an MPN physician. After the first medical visit, you may continue to be treated by that doctor, or you may choose another doctor from the MPN. You may continue to choose doctors within the MPN for all of your medical care for this injury.

If appropriate, you may choose a specialist or ask your treating doctor for a referral to a specialist. Some specialists will only accept appointments with a referral from the treating doctor. Such specialist might be listed as "by referral only" in your MPN directory.

If you need help in finding a doctor or scheduling a medical appointment, you may call the Medical Access Assistant.

Can I change providers?

Yes. You can change providers within the MPN for any reason, but the providers you choose should be appropriate to treat your injury. Contact the MPN Contact or your claims adjuster if you want to change your treating physician.

What standards does the MPN have to meet?

The MPN has providers for the entire State of California.

The MPN must give you access to a regional list of providers that includes at least three physicians in each specialty commonly used to treat work injuries/illnesses in your industry. The MPN must provide access to primary treating physicians within 30 minutes or 15 miles and specialists within 60 minutes or 30 miles of where you work or live.

If you live in a rural area or an area where there is a health care shortage, there may be a different standard.

After you have notified your employer of your injury, the MPN must provide initial treatment within 3 business days. If treatment with a specialist has been authorized, the appointment with the specialist must be provided to you within 20 business days of your request.

If you have trouble getting an appointment with a provider in the MPN, contact the Medical Access Assistant.

If there are no MPN providers in the appropriate specialty available to treat your injury within the distance and timeframe requirements, then you will be allowed to seek the necessary treatment outside of the MPN.

What if there are no MPN providers where I am located?

If you are a current employee living in a rural area or temporarily working or living outside the MPN service area, or you are a former employee permanently living outside the MPN service area, the MPN or your treating doctor will give you a list of at least three physicians who can treat you. The MPN may also allow you to choose your own doctor outside of the MPN network. Contact your MPN Contact for assistance in finding a physician or for additional information.

What if I need a specialist that is not available in the MPN?

If you need to see a type of specialist that is not available in the MPN, you have the right to see a specialist outside of the MPN.

What if I disagree with my doctor about medical treatment?

If you disagree with your doctor or wish to change your doctor for any reason, you may choose another doctor within the MPN.

If you disagree with either the diagnosis or treatment prescribed by your doctor, you may ask for a second opinion from another doctor within the MPN. If you want a second opinion, you must contact the MPN contact or your claims adjuster and tell them you want a second opinion. The MPN should give you at least a regional or full MPN provider list from which you can choose a second opinion doctor. To get a second opinion, you must choose a

doctor from the MPN list and make an appointment within 60 days. You must tell the MPN Contact of your appointment date, and the MPN will send the doctor a copy of your medical records. You can request a copy of your medical records that will be sent to the doctor.

If you do not make an appointment within 60 days of receiving the regional provider list, you will not be allowed to have a second or third opinion with regard to this disputed diagnosis or treatment of this treating physician.

If the second opinion doctor feels that your injury is outside of the type of injury he or she normally treats, the doctor's office will notify your employer or insurer and you. You will get another list of MPN doctors or specialists so you can make another selection.

If you disagree with the second opinion, you may ask for a third opinion. If you request a third opinion, you will go through the same process you went through for the second opinion.

Remember that if you do not make an appointment within 60 days of obtaining another MPN provider list, then you will not be allowed to have a third opinion with regard to this disputed diagnosis or treatment of this treating physician.

If you disagree with the third-opinion doctor, you may ask for an MPN Independent Medical Review (IMR). Your employer or MPN Contact will give you information on requesting an Independent Medical Review and a form at the time you select a third-opinion physician.

If either the second or third-opinion doctor or Independent Medical Reviewer agrees with your need for a treatment or test, you may be allowed to receive that medical service from a provider within the MPN, or if the MPN does not contain a physician who can provide the recommended treatment, you may choose a physician outside the MPN within a reasonable geographic area.

What if I am already being treated for a work-related injury before the MPN begins?

Your employer or insurer has a "*Transfer of Care*" policy which will determine if you can continue being temporarily treated for an existing work-related injury by a physician outside of the MPN before your care is transferred into the MPN.

If your current doctor is not or does not become a member of the MPN, then you may be required to see a MPN physician. However, if you have properly predesignated a primary treating physician, you cannot be transferred into the MPN. (If you have questions about predesignation, ask your supervisor.)

If your employer decides to transfer you into the MPN, you and your primary treating physician must receive a letter notifying you of the transfer.

If you meet certain conditions, you may qualify to continue treating with a non-MPN physician for up to a year before you are transferred into the MPN. The qualifying conditions to postpone the transfer of your care into the MPN are set forth in the box below.

Can I Continue Being Treated By My Doctor?

You may qualify for continuing treatment with your non-MPN provider (through transfer of care or continuity of care) for up to a year if your injury or illness meets any of the following conditions:

- **(Acute)** The treatment for your injury or illness will be completed in less than 90 days;
- **(Serious or Chronic)** Your injury or illness is one that is serious and continues for at least 90 days without full cure or worsens and requires ongoing treatment. You may be allowed to be treated by your current treating doctor for up to one year, until a safe transfer of care can be made.
- **(Terminal)** You have an incurable illness or irreversible condition that is likely to cause death within one year or less.
- **(Pending Surgery)** You already have a surgery or other procedure that has been authorized by your employer or insurer that will occur within 180 days of the MPN effective date, or the termination of contract date between the MPN and your doctor.

You can disagree with your employer's decision to transfer your care into the MPN. If you don't want to be transferred into the MPN, ask your primary treating physician for a medical report on whether you have one of the four conditions stated above to qualify for a postponement of your transfer into the MPN.

Your primary treating physician has 20 days from the date of your request to give you a copy of his/her report on your condition. If your primary treating physician does not give you the report within 20 days of your request, the employer can transfer your care into the MPN and you will be required to use an MPN physician.

You will need to give a copy of the report to your employer if you wish to postpone the transfer of your care. If you or your employer disagrees with your doctor's report on your condition, you or your employer can dispute it. See the complete Transfer of Care policy for more details on the dispute resolution process.

For a copy of the Transfer of Care policy, in English or Spanish, ask your MPN Contact.

What if I am being treated by a MPN doctor who decides to leave the MPN?

Your employer or insurer has a written "*Continuity of Care*" policy that will determine whether you can temporarily continue treatment for an existing work injury with your doctor if your doctor is no longer participating in the MPN.

If your employer decides that you do not qualify to continue your care with the non-MPN provider, you and your primary treating physician must receive a letter notifying you of this decision.

If you meet certain conditions, you may qualify to continue treating with this doctor for up to a year before you must choose a MPN physician. These conditions are set forth in the, "***Can I Continue Being Treated By My Doctor?***" box above.

You can disagree with your employer's decision to deny you Continuity of Care with the terminated MPN provider. If you want to continue treating with the terminated doctor, ask your primary treating physician for a medical report on whether you have one of the four conditions stated in the box above to see if you qualify to continue treating with your current doctor temporarily.

Your primary treating physician has 20 days from the date of your request to give you a copy of his/her medical report on your condition. If your primary treating physician does not give you the report within 20 days of your request, your employer's decision to deny you Continuity of Care with your doctor who is no longer participating in the MPN will apply, and you will be required to choose a MPN physician.

You will need to give a copy of the report to your employer if you wish to postpone the selection of an MPN doctor treatment. If you or your employer disagrees with your doctor's report on your condition, you or your employer can dispute it. See the complete Continuity of Care policy for more details on the dispute resolution process.

For a copy of the Continuity of Care policy, in English or Spanish, ask your MPN Contact.

What if I have questions or need help?

- **MPN Contact:** You may always contact the MPN Contact if you have questions about the use of the MPN and to address any complaints regarding the MPN.
- **Medical Access Assistants:** You can contact the Medical Access Assistant if you need help finding MPN physicians and scheduling and confirming appointments.
- **Division of Workers' Compensation (DWC):** If you have concerns, complaints or questions regarding the MPN, the notification process, or your medical treatment after a work-related injury or illness, you can call the DWC's Information and Assistance office at 1-800-736-7401. You can also go to the DWC's website at www.dir.ca.gov/dwc and click on "medical provider networks" for more information about MPNs.
- **Independent Medical Review:** If you have questions about the MPN Independent Medical Review process contact the Division of Workers' Compensation's Medical Unit at:

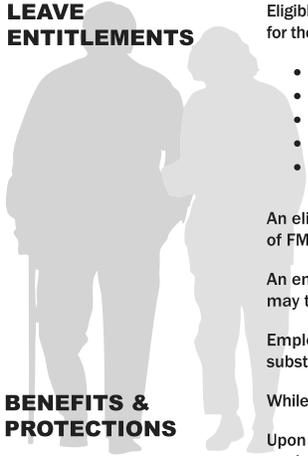
DWC Medical Unit
P.O. Box 71010
Oakland, CA 94612
(510) 286-3700 or (800) 794-6900

Keep this information in case you have a work-related injury or illness.

EMPLOYEE RIGHTS UNDER THE FAMILY AND MEDICAL LEAVE ACT

THE UNITED STATES DEPARTMENT OF LABOR WAGE AND HOUR DIVISION

LEAVE ENTITLEMENTS



Eligible employees who work for a covered employer can take up to 12 weeks of unpaid, job-protected leave in a 12-month period for the following reasons:

- The birth of a child or placement of a child for adoption or foster care;
- To bond with a child (leave must be taken within 1 year of the child's birth or placement);
- To care for the employee's spouse, child, or parent who has a qualifying serious health condition;
- For the employee's own qualifying serious health condition that makes the employee unable to perform the employee's job;
- For qualifying exigencies related to the foreign deployment of a military member who is the employee's spouse, child, or parent.

An eligible employee who is a covered servicemember's spouse, child, parent, or next of kin may also take up to 26 weeks of FMLA leave in a single 12-month period to care for the servicemember with a serious injury or illness.

An employee does not need to use leave in one block. When it is medically necessary or otherwise permitted, employees may take leave intermittently or on a reduced schedule.

Employees may choose, or an employer may require, use of accrued paid leave while taking FMLA leave. If an employee substitutes accrued paid leave for FMLA leave, the employee must comply with the employer's normal paid leave policies.

While employees are on FMLA leave, employers must continue health insurance coverage as if the employees were not on leave.

Upon return from FMLA leave, most employees must be restored to the same job or one nearly identical to it with equivalent pay, benefits, and other employment terms and conditions.

An employer may not interfere with an individual's FMLA rights or retaliate against someone for using or trying to use FMLA leave, opposing any practice made unlawful by the FMLA, or being involved in any proceeding under or related to the FMLA.

BENEFITS & PROTECTIONS

ELIGIBILITY REQUIREMENTS

An employee who works for a covered employer must meet three criteria in order to be eligible for FMLA leave. The employee must:

- Have worked for the employer for at least 12 months;
- Have at least 1,250 hours of service in the 12 months before taking leave;* and
- Work at a location where the employer has at least 50 employees within 75 miles of the employee's worksite.

*Special "hours of service" requirements apply to airline flight crew employees.

REQUESTING LEAVE

Generally, employees must give 30-days' advance notice of the need for FMLA leave. If it is not possible to give 30-days' notice, an employee must notify the employer as soon as possible and, generally, follow the employer's usual procedures.

Employees do not have to share a medical diagnosis, but must provide enough information to the employer so it can determine if the leave qualifies for FMLA protection. Sufficient information could include informing an employer that the employee is or will be unable to perform his or her job functions, that a family member cannot perform daily activities, or that hospitalization or continuing medical treatment is necessary. Employees must inform the employer if the need for leave is for a reason for which FMLA leave was previously taken or certified.

Employers can require a certification or periodic recertification supporting the need for leave. If the employer determines that the certification is incomplete, it must provide a written notice indicating what additional information is required.

EMPLOYER RESPONSIBILITIES

Once an employer becomes aware that an employee's need for leave is for a reason that may qualify under the FMLA, the employer must notify the employee if he or she is eligible for FMLA leave and, if eligible, must also provide a notice of rights and responsibilities under the FMLA. If the employee is not eligible, the employer must provide a reason for ineligibility.

Employers must notify its employees if leave will be designated as FMLA leave, and if so, how much leave will be designated as FMLA leave.

ENFORCEMENT

Employees may file a complaint with the U.S. Department of Labor, Wage and Hour Division, or may bring a private lawsuit against an employer.

The FMLA does not affect any federal or state law prohibiting discrimination or supersede any state or local law or collective bargaining agreement that provides greater family or medical leave rights.

For additional information or to file a complaint:

1-866-4-USWAGE

(1-866-487-9243) TTY: 1-877-889-5627

www.dol.gov/whd

U.S. Department of Labor | Wage and Hour Division





CFRA LEAVE REQUIREMENTS:

RETURN RIGHTS AFTER CFRA LEAVE:

ELIGIBILITY

- To be eligible for CFRA leave, an employee must have more than 12 months of service with the employer and have worked at least 1,250 hours for that employer in the 12-month period before the leave begins.
- An eligible employee may take an unpaid leave to bond with an adopted or foster child or to bond with a newborn.
- An eligible employee may take unpaid leave to care for a parent, registered domestic partner, or child with a serious health condition. CFRA leave may also be taken for the employee's own serious health condition.
- Full-time employees may take leave of up to 12 work weeks in a 12-month period. Part-time employees may take leave on a proportional basis. The leave does not need to be taken in one continuous period of time.
- An employer may require a 30-day advance notice of the need for a CFRA-qualifying leave. When this is not possible due to the unexpected nature of the qualifying event, notice should be given as soon as practicable. Notice can be written or verbal and should include the timing and the anticipated duration of the leave, but an employer may not require disclosure of an underlying diagnosis. An employer must respond to a leave request within 5 business days.
- The employer may require written communication from the health-care provider of the child, parent, registered domestic partner, or employee with a serious health condition stating the reasons for the leave and the probable duration of the condition. However, the health care

- provider may not disclose the underlying diagnosis without the consent of the patient.
- In addition to the family care and medical leave requirements of the CFRA, employers of five or more persons have additional obligations pertaining to pregnancy disability leave (PDL). Please refer to the DFEH publication "Pregnancy Leave" for more information.
- Employees are entitled to take CFRA leave in addition to any leave entitlement they might have under PDL. Leave taken for the birth or adoption of a child must be completed within one year of the event.

SALARY AND BENEFITS DURING CFRA LEAVE

Employers are not required to pay employees during a CFRA leave. An employer may require an employee to use accrued vacation time or other accumulated paid leave other than sick time. If the CFRA leave is for the employee's own serious health condition, the use of sick time can be required.

If the employer provides health benefits under a group plan, the employer must continue to make these benefits available during the leave. Similarly, the employee is entitled to continue accruing seniority and participate in other benefit plans.

1. After CFRA leave, employees are guaranteed a return to the same or comparable position and can request the guarantee in writing.

2. If the same position is no longer available, such as in a layoff or closure, the employer must offer a position that is comparable in terms of pay, benefits, shift, schedule, geographic location, and working conditions, including privileges, perquisites, and status, unless the employer can prove that no comparable position exists. An employee is not entitled to reinstatement if the employee would have been otherwise laid off or terminated.

FAMILY TEMPORARY DISABILITY INSURANCE (FTDI) OR "PAID FAMILY LEAVE"

Employees on CFRA leave of absence may also be eligible for six weeks of paid leave under FTDI, a program administered by the California Employment Development Department (ED). For further information, contact the EDD at (800) 480-3287 or visit ED's website at www.edd.ca.gov.



PREGNANCY LEAVE

COMPLAINTS MUST BE FILED WITHIN ONE YEAR OF THE LAST ACT OF DISCRIMINATION

FILING A COMPLAINT

THE MISSION OF THE DEPARTMENT OF FAIR EMPLOYMENT AND HOUSING IS TO PROTECT THE PEOPLE OF CALIFORNIA FROM UNLAWFUL DISCRIMINATION IN EMPLOYMENT, HOUSING AND PUBLIC ACCOMMODATIONS, AND FROM THE PERPETRATION OF ACTS OF HATE VIOLENCE AND HUMAN TRAFFICKING.

If you believe you are a victim of discrimination you may, within one year of the discrimination, file a complaint of discrimination with the Department of Fair Employment and Housing by following these steps:

- ① *Contact DFEH by using the information on the back of this brochure*
- ② *Be prepared to present specific facts about the alleged discrimination or denial of leave*
- ③ *Keep records and provide copies of documents that support the charges in the complaint, such as paycheck stubs, calendars, correspondence and other potential proof of discrimination*

DFEH will conduct an impartial investigation. We represent the State of California. DFEH will, if possible, try to assist both parties to resolve the complaint.

If a voluntary settlement cannot be reached, and there is sufficient evidence to establish a violation of the law, DFEH may issue a civil complaint and litigate the case in state or federal court.

If the court decides in favor of the complaining party, remedies may include reinstatement, back pay, reasonable attorney's fees and costs, damages for emotional distress, and punitive damages.

FOR MORE INFORMATION

Department of Fair Employment and Housing
Toll Free: (800) 884-1684
TTY: (800) 700-2320
Online: www.dfeh.ca.gov

Also find us on:



If you have a disability that prevents you from submitting a written pre-complaint form on-line, by mail, or email, the DFEH can assist you by scribing your pre-complaint by phone or, for individuals who are Deaf or Hard of Hearing or have speech disabilities, through the California Relay Service (711), or call us through your VRS at (800) 884-1684 (voice).

To schedule an appointment, contact the Communication Center at (800) 884-1684 (voice or via relay operator 711) or (800) 700-2320 (TTY) or by email at contact.center@dfeh.ca.gov.

The DFEH is committed to providing access to our materials in an alternative format as a reasonable accommodation for people with disabilities when requested.

Contact the DFEH at (800) 884-1684 (voice or via relay operator 711), TTY (800) 700-2320, or contact.center@dfeh.ca.gov to discuss your preferred format to access our materials or webpages.

The Fair Employment and Housing Act (FEHA), enforced by the California Department of Fair Employment and Housing (DFEH), contains provisions relating to pregnancy leave. These provisions cover all employers with five or more full or part time employees.

In addition, there are certain leave and transfer protections and guarantees provided under the FEHA and the California Family Rights Act (CFRA).

All employers must provide information about pregnancy leave rights to their employees and post information about pregnancy leave rights in a conspicuous place where employees tend to gather. Employers who provide employee handbooks must include information about pregnancy leave in the handbook.

IT IS UNLAWFUL FOR AN EMPLOYER TO DISCRIMINATE IN TERMS OF COMPENSATION, CONDITIONS, OR PRIVILEGES OF EMPLOYMENT BECAUSE OF PREGNANCY, CHILDBIRTH, OR RELATED MEDICAL CONDITIONS



RIGHTS AND OBLIGATIONS

LEAVE REQUIREMENTS

- An employee disabled by pregnancy, childbirth, or a related medical condition is entitled to up to four months of disability leave per pregnancy. If the employer provides more than four months of leave for other types of temporary disabilities, the same leave must be made available to employees who are disabled due to pregnancy, childbirth, or a related medical condition.
- Leave can be taken before or after birth during any period of time the employee is physically unable to work because of pregnancy or a pregnancy-related condition. All leave taken in connection with a specific pregnancy counts toward computing the four-month period.
- Pregnancy leave is available when an employee is actually disabled. This includes time off needed for prenatal or postnatal care, severe morning sickness, doctor-ordered bed rest, childbirth, recovery from childbirth, loss or end of pregnancy, or any other related medical condition.
- If an employee is disabled as the result of a condition related to pregnancy, childbirth, or associated medical conditions and requests reasonable accommodation upon the advice of the employee's health-care provider, an employer must provide reasonable accommodation.
- As an accommodation, and with advice of a physician, an employee can request transfer to a less strenuous or hazardous position or duties because of the employee's pregnancy.
- Employees are entitled to take pregnancy disability leave in addition to any leave entitlement they might have under CFRA. For example, an employee could take up to four months pregnancy disability leave for any period of disability, and also take up to 12 weeks CFRA leave to bond with the baby; to bond with an adopted child; or to care for a parent, spouse, or child with a serious health condition. CFRA leave may also be taken for the employee's own serious health condition. For more information, see DFEH's brochure entitled "California Family Rights Act."
- If possible, an employee must provide their employer with at least 30 days advance notice of the date for which the pregnancy disability leave or accommodation is sought and the estimated duration of the leave or accommodation.
- If 30 days advance notice is not possible due to a change in circumstances or a medical emergency, notice must be given as soon as practicable. The leave may be modified as an employee's changing medical condition dictates. If the reinstatement date differs from the original agreement, or if no agreement was made, an employer must reinstate the employee within two business days of being given notice that the employee intends to return. When two business days are not feasible, reinstatement must be made as soon as possible to expedite the employee's return.

SALARY AND BENEFITS DURING LEAVE

- Employers who provide health insurance coverage for employees who take leave for other temporary disabilities must provide coverage for employees who take leave for pregnancy, childbirth or related medical conditions.
- An employer may require an employee to use accrued sick leave during any unpaid portion of their pregnancy disability leave. The employee may also use vacation leave credits to receive compensation for which the employee is eligible. But an employer may not require an employee to use vacation leave or other accrued time off during pregnancy disability leave.

RETURN RIGHTS

- It is illegal for an employer to fire an employee because that employee is pregnant or taking pregnancy disability leave. Employers are required by law to reinstate employees to the same position those employees had before taking leave, and an employee may request this guarantee in writing. In some situations, an employee may be reinstated to a position that is comparable (same tasks, skills, benefits, and pay) to the job they had before taking PDL.
- However, pregnancy disability leave does not protect employees from employment actions not related to their pregnancy, such as layoffs.

Memo

**To: Adjunct Faculty
Classified Employees (less than 20 hours per week)
Temporary Employees**

From: Human Resources

Re: Notice of Social Security Alternative Plan – National Benefit Services (NBS)

If an employee is not eligible to contribute to CalPERS or CalSTRS, they will be automatically enrolled in a Social Security Alternative Plan (SSAP). Mt. San Antonio College contracts with National Benefit Services (NBS) to provide a 457(b) plan to employees.

The Social Security Alternative Plan (SSAP) was established July 1, 1991 to comply with changes in federal law requiring public employers to provide social security coverage to all employees, unless they are members of a public retirement system or covered under a Section 218 Agreement. Public employers had the option to create FICA “Social Security” Alternative Plans which the College did for employees who were not members of California State Teachers’ Retirement System (CalSTRS) or California Public Employees Retirement System (CalPERS). These employees could include adjunct faculty, classified staff employed less than 20 hours per week, and temporary hourly employees who work less than 1,000 hours per fiscal year. Under this plan, employees contribute 4.5% of their earnings to the 457(b) retirement account and the College contributes an additional 3%. Employees are immediately vested in the plan which means they can withdraw or transfer 100% of the account balance upon separation of employment with the College.

In general, a 457(b) plan offers the following benefits:

- Pre-tax contributions reducing current federal taxable income
- Potential investment return growth; tax-deferred until paid or distributed
- Convenient payroll reduction
- Account balance is portable to another eligible retirement plan if you change jobs
- Employees planning to retire before age 55: Although in-service distributions are generally restricted until age 70½ under a 457(b) plan, a distribution from a 457(b) plan upon separation from service is generally not subject to an additional 10 percent federal penalty tax that applies to early distributions from a 403(b) or IRA.

For additional information regarding your 457(b) plan, contact NBS at 1-800-274-0503 or via their website at www.nbsbenefits.com/403b.

FICA Alternative Retirement Plan

What is a 457(b) FICA Alternative Retirement Plan?

A 457(b) FICA Alternative Retirement Plan is a qualified retirement plan which takes the place of Social Security for government entities such as school districts, cities, etc.

When did this type of plan get started?

In 1990, the Omnibus Budget Reconciliation Act was passed. Government entities who exercised their Social Security Section 218 exclusion (located in Section 3121 of the IRS Code) were provided the option of giving their part-time, temporary, and seasonal employees a meaningful, defined contribution retirement plan as an alternative to Social Security. Medicare contributions would continue as before. Once a government entity opts into this type of plan, they must continue the administration of the plan.

Am I eligible to contribute to this plan?

If your type of employment is considered part-time, temporary, or seasonal, and the state and government entity opted for this plan, then you are eligible to contribute to the FICA Alternative Retirement Plan and you will automatically be enrolled. Retired participants that are currently receiving their State Pension for Retired Teachers are not eligible to contribute to the 457(b) FICA Alternative Plan. They are eligible for distribution from the plan.

How much can I contribute to this plan?

Eligible employees contribute a flat rate of 4.5% of each paycheck (below the 6.2% Social Security tax). Funds are contributed, pre-tax, so taxes are deferred until the money is distributed.

How can I invest my money in the plan?

Generally, the funds are placed in an investment that doesn't decrease in value. The funds are placed in an investment model of the employer's choosing.

How often will I receive account statements?

Statements are sent annually after the employer plan-year ends. The participant can call NBS to request additional statements or inquire about their account balance. Participants should update their address with the district and NBS to ensure that they receive their yearly statements.

How do I qualify to withdraw money out of the plan?

Participants are eligible to withdraw the funds from the plan upon separation of service, if the employer verifies eligibility and the employer does not have a mandatory waiting period for the employee's account reconciliation. If the employee changes jobs, he or she may be eligible to leave their funds in the plan until a withdrawal is requested. All funds contributed to the 457(b) FICA Alternative plan are always 100% vested.

Withdrawal Options:

- Cash Out
- Rollover to another eligible retirement plan
- Transfer - Purchase service credit (air time) from their State Pension for Retired Teachers
- Transfer to another employer's 457(b) FICA Alternative plan

What are the options for distribution and what are the tax consequences?

The account is paid out as one lump sum (unless a Required Minimum Distribution is requested). If the participant chooses to have the funds sent directly to him or her, a check will be sent. Mandatory 20% federal taxes (and state taxes, if applicable) will be paid at the time of distribution. There are no additional tax penalties for early distribution.

Can I ever opt out of the 457(b) FICA Alternative Plan?

All eligible employees are required to participate, per IRS regulations.

Contact us for more information.

1(800) 274-0503

Email: 403bsupport@nbsbenefits.com
or visit www.nbsbenefits.com/403b