COLOR KEY

Employee

Admin/Manager

**Human Resources** 

## MT. SAN ANTONIO COLLEGE Temporary Hiring Checklist

Name:		Banner ID: Leave blank if unknown					
to ensure a	Please complete and attach this checklist to the Temporary Employment Form and new hire documents to ensure all required paperwork is complete prior to submission to Human Resources. <b>INCOMPLETE PAPERWORK MAY CAUSE CONSIDERABLE DELAY IN EMPLOYEE RECEIVING PAY WARRANTS PROMPTLY.</b>						
Employee Received	Returned To HR	Required Paperwork:					
		Temporary Employment Form					
		Online Application Number Confirmation Received					
		Withholding Forms – Federal & State					
		Employment Eligibility Verification - I-9 Form (Instructions and list of acceptable documents on reverse side of I-9)					
		Social Security card (for IRS purposes)					
		Oath of Allegiance					
		Warrant Designation					
		Confidentiality and Appropriate Work Attire Agreement Form					
		Hepatitis B Vaccination Program and Acknowledgement Form					
		Asbestos Notification and Acknowledgement Form					
		FMLA Information and Acknowledgement Form					
		Non-Discrimination Statement and Acknowledgement Form					
		District Policy on Drug Free Environment and Acknowledgement Form					
		Reasonable Accommodation Information and Acknowledgement Form					
		Sexual Harassment Brochure and Acknowledgement Form					
	Use of Technology and Information Resources and Employee Acceptable Use Agreement (AP 3720) and Acknowledgement Form						
	П	Notice of Exclusion from CalPERS Membership					
		CalPERS Reciprocal Self- Certification Form					
	Worker's Compensation Pre-Designation Personal Physician Form						
		Optional Paperwork:					
		Direct Deposit Authorization Form ☐ (attached voided check)					
		Informational Paperwork (For employee records):					
		Emergency Response Quick Reference Guide					
		Disaster Service Workers Brochure					

HR Use Only:	
<del></del>	e 2810.5) including Wage Information/Worker's Compensation/Paid
Sick Leave/Affordable Care Act ge	enerated and sent to employee.
Date:	HRT:

Notice of Social Security Alternative Plan - National Benefit Services (NBS)

Worker's Compensation Information FMLA, PDL, and CFRA Information

New Hire: Returning: Last			First			I ANTON ary Emplo	oymen	t Forn	n	red First		anner A#:
Name:			Name:				MI:	I	Name	(Optional)	: _	
Address:					(	City:			S	State:	•	Zip Code:
Gender: Male Defined Male		DOB:		Phone :				Email				
l am	a CalPERS	S member	Yes 🗌	No 🗌		If ye	s, are y	ou a ret	tired C	CalPERS m	emk	oer?: Yes 🗌 No 🗌
	EMERGENCY CONTACT INFORMATION											
Name							_		_	Talanhana	ш.	
Name:  I have verified my m												mailed
EMPLOYEE SIGNA	_						ayoneok	a cripi	Oymen	Date:		
						mpleted b	v Dena	rtment	t Hirin			
		F	malovo	o Classi	ficatio	n (Por Ed (	Codo Se	ction 8	8003)		ity	
		lease choo	se Sele	ect on	e pos	sition & Lo	evel yo	u are re	equesti	ing to hire.		
Administrative Support					IV V  Ute  Grounds)							
		epartment		irenity '	WOIKII	ng in any ot Man	ager:	artificii	tr. ie		J 	<u></u>
	If yos are					nstructiona e general d					, c	l No
Department Name:		o ano dane	o portor	ica un	aur til	Online					, <u> </u>	J 110
Department Locati	on:											
Hourly	Start				End			Dep	artme	nt Contact	/Ext	ension:
Rate: Position #	Date:	d (	Organiza	ation	Date:	ccount	Pro	gram	C	Check box if a	addin	g a new account string <u>ONLY</u> ,
			<u> </u>									ve dates & manager initial
												ds must include new
												ger initial with date and account string
										[aa.	.54 6	9
	<u> </u>	Print	& sign	legibl	y URI	ES AND AP	PROVAI	LS				
Manager Print (Required):				Manag (Requir	er Sign					D	ate (	Required):
VP Signature/Date:				HR Init		<del>)</del> :			Boar	d Approval [	Date:	)
Student	s do not	need VF	sig									

#### Whiteout is not allowed on federal forms

## Form W-4 (2017)

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

Exemption from withholding. If you are exempt, complete only lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2017 expires February 15, 2018. See Pub. 505, Tax Withholding and Estimated Tax.

Note: If another person can claim you as a dependent on his or her tax return, you can't claim exemption from withholding if your total income exceeds \$1,050 and includes more than \$350 of unearned income (for example, interest and dividends).

Exceptions. An employee may be able to claim exemption from withholding even if the employee is a dependent, if the employee:

- Is age 65 or older,
- Is blind, or
- Will claim adjustments to income: tay credits: or

The exceptions don't apply to supplemental wages greater than \$1,000,000.

Basic instructions. If you aren't exempt, complete the Personal Allowances Worksheet below. The worksheets on page 2 further adjust your withholding allowances based on itemized deductions, certain credits, adjustments to income, or two-earners/multiple jobs situations.

Complete all worksheets that apply. However, you may claim fewer (or zero) allowances. For regular wages, withholding must be based on allowances you claimed and may not be a flat amount or percentage of wages

Head of household. Generally, you can claim head of household filing status on your tax return only if you are unmarried and pay more than 50% of the costs of keeping up a home for yourself and your dependent(s) or other qualifying individuals. See Pub. 501, Exemptions, Standard Deduction, and Filing Information, for information.

Tax credits. You can take projected tax credits into account in figuring your allowable number of withholding allowances. Credits for child or dependent care expenses and the child tax credit may be claimed using the Personal Allowances Worksheet below.

Nonwage income. If you have a large amount of nonwage income, such as interest or dividends, consider making estimated tax payments using Form 1040-ES, Estimated Tax for Individuals. Otherwise, you may owe additional tax. If you have pension or annuity income, see Pub. 505 to find out if you should adjust your withholding on Form W-4 or W-4P.

Two earners or multiple jobs. If you have a working spouse or more than one job, figure the total number of allowances you are entitled to claim on all jobs using worksheets from only one Form W-4. Your withholding usually will be most accurate when all allowances are claimed on the Form W-4 for the highest paying job and zero allowances are claimed on the others. See Pub. 505 for details.

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

Check your withholding. After your Form W-4 takes effect, use Pub. 505 to see how the amount you are having withheld compares to your projected total tax for 2017. See Pub. 505, especially if your earnings exceed \$130,000 (Single) or \$180,000 (Married).

Future developments. Information about any future developments affecting Form W-4 (such as

	ed deductions, on his	or her tax return.	See Pub. 505 for information credits into withholding allow		er legislation at <i>www.ir</i> :	i enacted after we s. <i>gov/w4</i> .	release it) will be posted	
		Persona	al Allowances Works	<b>heet</b> (Keep for y	our records.)			
Α	Enter "1" for you	rself if no one else can	claim you as a dependent				A	
	(	<ul> <li>You're single and hav</li> </ul>	e only one job; or			)		
В	Enter "1" if:		only one job, and your spo			} .	В	
		•	cond job or your spouse's v	• '				
С	•	•	choose to enter "-0-" if y			• .	or more	
	than one job. (En	tering "-0-" may help yo	ou avoid having too little to	ax withheld.)			· · c	
D			your spouse or yourself)					
E	-		ehold on your tax return (s				E	
F	-		hild or dependent care e				F	
			ments. See Pub. 503, Chil					
G		`	nild tax credit). See Pub. 9	,	•			
			0,000 (\$100,000 if married "2" if you have five or mo		n eligible child; t	hen <b>less "</b> 1" if	you	
		=	000 and \$84,000 (\$100,000	=	urriad) antar "1" 1	or and aligible	child. <b>G</b>	
Н	•		<b>Note:</b> This may be different t		•	•		
п	Add lines A throug	,	·			•	,	
	For accuracy,	and Adjustments Wo	e or <b>claim adjustments to i</b> * <b>ksheet</b> on page 2.	ncome and want to	reduce your with	nolaing, see the	Deductions	
	complete all	If you are single and	have more than one job	or are <b>married and y</b>	ou and your spo	use both work	and the combined	
	worksheets	1	exceed \$50,000 (\$20,000 if				sheet on page 2	
	that apply.	Contact Payr	oll if you have que	stions on com	pleting this	torm of Fo	rm W-4 below.	
		Separate nere and	give Form W-4 to your en	nployer. Keep the to	op part for your	recoras		
	W_4	Employe	ee's Withholding	g Allowance	Certificat	e	OMB No. 1545-0074	
Form	was and a fither Transcourse	► Whether you are en	- titled to claim a certain numb	er of allowances or ex	emption from with	nholding is	2017	
	ment of the Treasury Il Revenue Service	subject to review by	the IRS. Your employer may b	e required to send a	opy of this form to	the IRS.		
1	Your first name ar	nd middle initial	Last name			2 Your social	security number	
	Home address (nu	ımber and street or rural rout	<b>e)</b>				at higher Single rate.	
	0:4						alien, check the "Single" box.	
	City or town, state	e, and ZIP code		4 If your last name differs from that shown on your social security card, check here. You must call 1-800-772-1213 for a replacement card. ▶				
		f II						
5		•	aiming (from line <b>H</b> above			n page 2)	<b>5 6</b> \$	
7	•	•	· · · · · · · · · · · · · · · · · · ·		•	•	ori.	
	•	•	all federal income tax with eral income tax withheld b		-			
	•	•	empt" here	•		7		
Unde	•	-	xamined this certificate and			lief, it is true. co	orrect, and complete.	
		,,		,	J	, , 0	. ,	
	loyee's signature form is not valid ur	nless you sign it.) ▶				Date ▶		
8		, , ,	onlete lines 8 and 10 only if sen	ding to the IRS ) 9 (	Office code (ontional)		dentification number (FIN)	

### Whiteout is not allowed on federal forms



This form can be used to manually compute your withholding allowances, or you can electronically compute them at www.taxes.ca.gov/de4.pdf.

state of Cali

Contact Payroll if you have questions on completing this form

#### EMPLOYEE'S WITHHOLDING ALLOWANCE CERTIFICATE

Type or Print Your Full Name	Your Social Security Number				
Home Address (Number and Street or Rural Route)	Filing Status Withholding Allowances				
	☐ SINGLE or MARRIED (with two or more incomes)				
City, State, and ZIP Code	MARRIED (one income)				
	☐ HEAD OF HOUSEHOLD				
A ALL CHI CONTROLLED IN AN ILL CO					
1. Number of allowances for Regular Withholding Allowances, Worksheet A	<del></del>				
Number of allowances from the Estimated Deductions, Worksheet B					
Total Number of Allowances (A + B) when using the California Withholding Schedules for 2017					
OR					
2. Additional amount of state income tax to be withheld each pay period (if employer agrees), Worksheet C					
OR					
3. I certify under penalty of perjury that I am not subject to California withholding	g. I meet the conditions set forth under				
the Service Member Civil Relief Act, as amended by the Military Spouses Resid	lency Relief Act. (Check box here)				
Under the penalties of perjury, I certify that the number of withholding					
number to which I am entitled or, if claiming exemption from withhold	ing, that I am entitled to claim the exempt status.				
Signature	Date				
Employer's Name and Address	California Employer Account Number				
Mt. San Antonio College	Camornia Employer Account Number				
1100 N. Grand Avenue					
Walnut, Ca 91789					
cut nere					
Give the top portion of this page to your employer and keep the remainder for you	ır records.				

YOUR CALIFORNIA PERSONAL INCOME **tax may be underwithheld** if you do not file this de 4 form.

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

**PURPOSE**: This certificate, DE 4, is for **California Personal Income Tax (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.

You should complete this form if either:

- (1) You claim a different marital status, number of regular allowances, or different additional dollar amount to be withheld for California PIT withholding than you claim for federal income tax withholding or,
- (2) You claim additional allowances for estimated deductions.

THIS FORM WILL NOT CHANGE YOUR FEDERAL WITHHOLDING ALLOWANCES.

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

**certificate for your state income tax withholding, you may be significantly underwithheld.** This is particularly true if your household income is derived from more than one source.

**CHECK YOUR WITHHOLDING:** After your Form W-4 and/or DE 4 takes effect, compare the state income tax withheld with your estimated total annual tax. For state withholding, use the worksheets on this form.

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



### **Employment Eligibility Verification**

#### **Department of Homeland Security**

U.S. Citizenship and Immigration Services

USCIS Form I-9

OMB No. 1615-0047 Expires 08/31/2019

### Whiteout is not allowed on federal forms

► 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.

<b>Section 1. Employee Information and Attestation</b> (Employees must complete and sign Section 1 of Form I-9 no later than the <b>first day of employment</b> , but not before accepting a job offer.)						
Last Name (Family Name)	First Name (Given Name	re)	Middle Initial	Other La	ast Name	s Used (if any)
Address (Street Number and Name)	Apt. Number	City or Town			State	ZIP Code
Date of Birth (mm/dd/yyyy)  U.S. Social Sec	urity Number Emplo	yee's E-mail Addr	ress	Er	nployee's	Telephone Number
I am aware that federal law provides for connection with the completion of this f		r fines for false	statements o	r use of	false do	cuments in
I attest, under penalty of perjury, that I a	m (check one of the	following boxe	es):			
1. A citizen of the United States						
2. A noncitizen national of the United States	(See instructions)					
3. A lawful permanent resident (Alien Reg	gistration Number/USCIS	Number):	If check	ed includ	e #	
4. An alien authorized to work until (expira Some aliens may write "N/A" in the expira	• • •		checked include	e date		
Aliens authorized to work must provide only or An Alien Registration Number/USCIS Number					Do	QR Code - Section 1 Not Write In This Space
Alien Registration Number/USCIS Number:     OR			_			
2. Form I-94 Admission Number: OR			_			
3. Foreign Passport Number:			_			
Country of Issuance:			_			
Signature of Employee			Today's Date	e (mm/dd/	(yyyy)	
Preparer and/or Translator Certification (check one):  I did not use a preparer or translator.  A preparer(s) and/or translator(s) assisted the employee in completing Section 1.  (Fields below must be completed and signed when preparers and/or translators assist an employee in completing Section 1.)						
I attest, under penalty of perjury, that I have assisted in the completion of Section 1 of this form and that to the best of my knowledge the information is true and correct.						
Signature of Preparer or Translator				Today's D	ate (mm/	dd/yyyy)
Last Name (Family Name) First Name (Given Name)						
Address (Street Number and Name)		City or Town			State	ZIP Code
					1	1

TOP| Employer Completes Next Page s

Form I-9 11/14/2016 N Page 1 of 3



## **Employment Eligibility Verification**

#### **Department of Homeland Security**

U.S. Citizenship and Immigration Services

USCIS Form I-9

OMB No. 1615-0047 Expires 08/31/2019

#### Section 2. Employer or Authorized Representative Review and Verification (Employers or their authorized representative must complete and sign Section 2 within 3 business days of the employee's first day of employment. You must physically examine one document from List A OR a combination of one document from List B and one document from List C as listed on the "Lists of Acceptable Documents.") Citizenship/Immigration Status Last Name (Family Name) First Name (Given Name) M.I. **Employee Info from Section 1** List A OR List B **AND** List C **Identity and Employment Authorization** Identity **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) List "A" may require multiple documents if applicable Document Title QR Code - Sections 2 & 3 Issuing Authority Do Not Write In This Space use one item to fulfill "List B" & "List C" Do NOT over-document Document Number A Social Security card must still be submitted for Expiration Date (if any)(mm/dd/yyy Payroll purposes regardless 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 Must be completed by permanent employee First Name of Employer or Authorized Representative Employer's Business or Organization Name Last Name of Employer or Authorized Representative Mt. San Antonioi College State Employer's Business or Organization Address (Street Number and Name) City or Town ZIP Code Walnut, Ca CA 91789 1100 N. Grand Avenue tion 3. Reverification and Rehires (To be completed and signed by employer or authorized representative.) B. Date of Rehire (if appl A. New Name Last Name (Family Nam First Name (Given Name) Middle Initial Date (mm/e C. If the employee's previous grant of employment auth has expired, provide " mation for the document or receipt that establishes continuing employment authorization in the space provided below Document Title Expiration Date (if any) (mm/dd/yyyy) the best of my knowledge, this employee is authorized work in the United States, and if I attest, under penalty of perjury the employee presented ament(s), the document(s) I have examined appear to be genuine and to the individual. yer or Authorized Representative Today's Date (mm/dd/yyyy) Name of Employer or Authorized Repre

### LISTS OF ACCEPTABLE DOCUMENTS

Use this page as a guide and/or for samples on acceptable items for List A or B & C

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

	or a combination				
	LIST A		LIST B		LIST C
	Documents that Establish  Both Identity and  Employment Authorization	OR .	Documents that Establish Identity	שו	Documents that Establish Employment Authorization
		-	7		
1.	U.S. Passport or U.S. Passport Card	1.	Driver's license or ID card issued by a	1.	A Social Security Account Number
2.	Permanent Resident Card or Alien Registration Receipt Card (Form I-551)		State or outlying possession of the United States provided it contains a photograph or information such as		card, unless the card includes one of the following restrictions: (1) NOT VALID FOR EMPLOYMENT
3.	Foreign passport that contains a temporary I-551 stamp or temporary		name, date of birth, gender, height, eye color, and address		(2) VALID FOR WORK ONLY WITH INS AUTHORIZATION
	I-551 printed notation on a machine- readable immigrant visa	2.	ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or		(3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION
4.	Employment Authorization Document that contains a photograph (Form I-766)		information such as name, date of birth, gender, height, eye color, and address	2.	Certification of Birth Abroad issued by the Department of State (Form FS-545)
	For a nonimmigrant alien authorized	3.	School ID card with a photograph	3.	Certification of Report of Birth
5.	to work for a specific employer because of his or her status:	4.	Voter's registration card		issued by the Department of State (Form DS-1350)
	a. Foreign passport; and	5.	U.S. Military card or draft record	4	Original or certified copy of birth
	<b>b.</b> Form I-94 or Form I-94A that has	6.	Military dependent's ID card	٠.	certificate issued by a State, county, municipal authority, or
	the following: (1) The same name as the passport;	7.	U.S. Coast Guard Merchant Mariner Card		territory of the United States bearing an official seal
	and (2) An endorsement of the alien's	8.	Native American tribal document	5.	Native American tribal document
	nonimmigrant status as long as that period of endorsement has	9.	Driver's license issued by a Canadian government authority	6.	U.S. Citizen ID Card (Form I-197)
	not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form.		For persons under age 18 who are unable to present a document listed above:		Identification Card for Use of Resident Citizen in the United States (Form I-179)
_			iisteu abuve.	8.	Employment authorization
6.	Passport from the Federated States of Micronesia (FSM) or the Republic of	10	School record or report card		document issued by the Department of Homeland Security
	the Marshall Islands (RMI) with Form I-94 or Form I-94A indicating	1	Clinic, doctor, or hospital record		Department of Floridana occurry
	nonimmigrant admission under the Compact of Free Association Between the United States and the FSM or RMI	12	2. Day-care or nursery school record		

Examples of many of these documents appear in Part 8 of the Handbook for Employers (M-274).

Refer to the instructions for more information about acceptable receipts.

Form I-9 11/14/2016 N Page 3 of 3



### **HUMAN RESOURCES**

## **OATH OF ALLEGIANCE**

(Required by Government Code)

	Print name			
"			do sole	emnly swear (or
affirm) that I will support Constitution of the State of bear true faith and allegian the State of California; the purpose of evasion; and the about to enter."	of California aga nce to the Const at I take this ob	ninst all enemies, itution of the Unit pligation freely, w	of the United foreign and do led States and the led out on the led out of the led	States and the mestic; that I will he Constitution of tal reservation of
			Signa	nture of Employee
THE OATHS ABOVE SU		1 V O E	TO BEFORE M	ME ON THIS
	Must be permanent	employee		
WITNESS TITLE:	Must be permanent	t employee		



### **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 I hereby designate all warrants payable to me.				
Name of DESIGNEE: Relationship:				
Address:	City:	State:	Zip:	
Telephone:				
This designation form cancels purpose and shall remain in effe			signed for this	
It is understood and agreed the said warrants to the designee the school district and provides negotiate the warrant(s) as if the	unless the designates sufficient proof or	ated person claims sucl	n warrants from	
School District/Agency:	Mt. San	Antonio College		
EMPLOYEE:		Date:		

#### 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.

Circle one choice only 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 EMPLOYEE ASBESTOS NOTIFICATION

,	, hereby acknowledge receipt of the
Employee Asbestos Notification. contained in the Employee Asbestos	I have read and understand the information Notification.
Print Name	Date
Signature	

Rev. 1/2008; LR 9.7.2016, 7/20/17

## 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 COLLEGE NON-DISCRIMINATION STATEMENT

the AP 3410 Nondiscrimination police	<b>College Non-Discrimination Statement</b> (dated 8/25/16) and y. Upon receiving this policy I further acknowledge that I have lat I have a reasonable understanding of the policy. I also f this policy.
Print Name	Date
Signature	

### 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	

## 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
Circo et une	
Signature	

## 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
Till Name
Signature Signature

#### **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	



# If employee is already active in CalPERS DO NOT complete this form

### NOTICE OF EXCLUSION FROM Calpers MEMBERSHIP

2. C			Your employer has contracted with the California Public Employees' Retirement System (CalPERS) to provide an employee benefit package which includes service retirement, death, and disability benefits.								
2.	URRE	NT NAME (LAST)	(FIRST)	IDDLE)							
-		OF PUBLIC AGENCY N ANTONIO COLLEGE	4. DEPARTMENT OR SCHOOL D	DISTRICT 5.	5. JOB OR POSITION TITLE						
6. <b>T</b>	ERM C	OF APPOINTMENT	7. IF TEMPORARY, ENTER NEAREST OF WHOLE MONTHS THE APPOINT EXPECTED TO LAST.	MENTIC	8. APPOINTMENT DATE  MM DD YYYY						
PE	RMAN	NENT TEMPORARY		ONTHS	Ctout data						
	JLL-TI		E PART-TIME IF PART TIME, E	ENTER THE FRACTI	Start date ON OF FULL TIME:						
In y	our p	present position with thi	s agency, you are excluded from	CalPERS memb	pership because:						
	1.	Your full-time seasonal c	r limited term appointment is limited	to 6 months or le	ess.						
	2.	Your part-time appointment one year.	ent is limited to less than an average	e of 20 hours per	week for less than						
₽	3.		n-call, intermittent, emergency, subs pership until you have worked 1,000 ar.								
	4.	Your position is excluded	d by law or by contract agreement w	hich excludes:							
			Enter contract exclusion	(for Public Agencies	only).						
	5.	You are an independent	contractor.								
	6.		nder professional legal service to a city. the office of city attorney, deputy city attorney, or assistant city attorney.								
	7.		student aide by a school district in a position established for students ing school in the same district (for County Schools only).								
	de in	eposit or service credit), ex your present position. Be	r of CalPERS by previous employm cclusions 1, 2, and 3 do not apply to sure to notify your employer to com a ACES to report your employment	you and you sho plete a (PERS-1)	ould be a member						
for ar why y	n exp you f	olanation. You can also d feel you should be a mer	ent <u>does</u> qualify you for CalPERS contact CalPERS directly by send mber to the Employer Account Ma 12709, Sacramento, CA 94229-270	ling a letter stati anagement Divis	ng the reasons						
SIGNA	TURE	OF CERTIFYING OFFICER	TITLE		DATE						
		HR ONLY	HR ON	LY	HR ONLY						

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

PERS-EAMD-139 (3/17)

## Complete if prior membership exists



Choose one

California Public Employees' Retirement System P.O. Box 942709 Sacramento, CA 94229-2709 888 CalPERS (or 888-225-7377)

TTY: (877) 249-7442 | Fax: (916) 795-4166

www.calpers.ca.gov

#### **RECIPROCAL SELF-CERTIFICATION FORM**

Complete the following information and return this form to your Personnel Office within 10 business days

Employee Name	(Last)	(F	irst)		(Middle)		
Date of Birth:			CalPERS ID:				
Check the applic	cable statement:						
	ot been a member of a qualify	ying Public I	Retirement S	ystem in C	alifornia.		
I have p	rior membership under anoth	ner Public Re	etirement Sys	stem in Cal	ifornia. <i>(Co</i>	-	
	cluding <u>month, date, and year</u>			e dates, pl	ease conta	ct the Public	Retirement
system to confil	rm information prior to compl	ieung Jorm	.)				
Name of Most Red	cent Reciprocal System:	Membersh /	nip Date:	Separation /	n Date*:	Retired*	* Refunded*
Name of Prior Rec	iprocal System:	Membersh	nip Date:	Separation	n Date*:	Retired*	* Refunded*
		/	<b>/</b>	/	<b>/</b>	Date: /	<b>(</b> )
Name of Prior Rec	iprocal System:	Membersh	nip Date:	Separation	Date*:	Retired*	* Refunded*
		/	1	/	//	Date: /	1
*Please provide	dates, if applicable. Not all sed	ctions may	be applicable	for each F	Reciprocal S	System.	
	at by accepting employment in nat system. I also understand	-		-	-		
incorrect may re not limited to, m	that the foregoing information equire corrections to my accounty my retirement enrollment level colled and eligible to receive th	unt in the Ca I. CalPERS r	alifornia Publ may make an	ic Employe y necessar	es' Retiren	nent System i	including, but
Employee Signatu	re		Date				
TO BE COMPLET	TED BY EMPLOYER ONLY: (Hun	nan Resources	Use Only)				
Name of CalPERS	Agency:	CalPERS Bus	iness Partner I	ID: Emplo	oyee's CalPE	RS Original Hir	e Date:
Mt. San Anto		12284890			•	J	
Designee of Emplo		Title)		Emplo	oyee's CalPE	RS Membershi	p Eligibility Date:
Designee's Signatu	ıre:			(Date)			
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# Contact Risk Management if you have questions regarding this form

(909)274-4230 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 predesignated, personal physician, the physician must agree, in writing, to treat you for a work-related injury, must have previously directed your medical care, and must retain your medical history and records. Your predesignated physician must be a family practitioner, general practitioner, board certified or board eligible internist, obstetrician-gynecologist or pediatrician. Your "personal physician" may be a medical group if it is a single corporation or partnership composed of licensed doctors or medicine or osteopathy that operates an integrated multi-specialty medical group providing comprehensive medical services predominantly for nonoccupational illnesses and injuries.

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

Гиан	Januara A alabaran				
Emp	oloyee Address:				
City:	)		State:	Zip Coo	de:
se	I acknowledge receipt of this form and receive medical treatment from my employ my mind and provide written notification prior to an industrial injury.	oloyers' medical provider.	I understand that, at	any time in the	future, I can d
	If I am injured on the job, I wish to be tre	ated by my personal physi	cian*:		
Phys	sician Name / Medical Group:		F	hone: () _	
Phys	sician / Medical Group Address:				
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Insur	rance Company, Plan, or Fund providing H				
		ealth coverage for non-oc	cupational injuries or	illnesses.	
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## This form is optional. Contact payroll with any questions



For District Use Only

## Mt. San Antonio College

1100 North Grand Avenue Walnut, California 91789-1399 www.mtsac.edu

Date:\_

#### **Direct Deposit Authorization**

Step	_	Check the	e Appro	priate Bo	X			-									
		Employ	yee			Vendo	or			Stude	nt (F	inancial A	Aid)				
_		Check th	e Appro	priate Bo	ox	1											
		New Ro	equest	ation	☐ Cancel Direct Deposit												
Step 2 Employee/Student/Vendor Information																	
_	Nam dor Na							1		First Name						Middle Initial	
		/Student/\ er (Requi		Α				E-mail Address									
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ACC	COU	INT HOL	DER S	SIGNAT	URE	<b>≣:</b>							DA	TE:			
Step	3																
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	S	taple voided	d check h	ere (DO NO	T attach	n a deposit sl	ip) <u>OR</u>	Have bank rep	reser	ntative comp	ete her	re					
♥							TC	BE COMP	PLE.	TED BY	YOU	R BANK			<b>⟨</b> }		
	NAME	E OF YOUR BA	ANK:														
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Revis	ed 10/3	31/16															

Input by: