Yosemite Community College District
Human Resources

STUDENT WORKER – New Hire Documents

Please use 1st day of start of work when signing all documents. Human Resources has provided the following checklist to assist you.

Sign & return the following:

- ☐ **Student Worker Application**
- ☐ **Student Employment Confirmation Form**
- ☐ **Fingerprint & Criminal History Background Check.** At employee expense. Additional information enclosed. Required within a maximum of 10 working days from the date of employment.
- ☐ **I-9 Form – Employment Eligibility Verification.** Verifies you are legally eligible to work in the U.S. Complete Section 1. Date with first day of work. See "List of Acceptable Documents" and provide identification from that list.
- ☐ **Oath of Affirmation.**
- ☐ **Policy Acknowledgement**
- ☐ **Confidentiality Statement for Student Workers**
- ☐ **Emergency Contact Information**
- ☐ **W-4 Form.** Use your legal name (as listed on your Social Security card) and mailing address.
- ☐ **EDD Employee's Withholding Allowance Certificate.** This form is required for state income tax withholding.
- ☐ **CalPERS Notice of Exclusion.** You are employed as a student aide (worker) by a school district in a position established for students only and you are attending school in the same district, which excludes you from membership.
- ☐ **Statement Concerning your Employment in a Job Not Covered by Social Security.**
- ☐ **Payroll Direct Deposit.** (Optional) Use for direct deposit, and attach a voided personal check.
- ☐ **Affordable Care Act Notice.** For your information only.

Students have the right to know:

*What skills are required for a position
*The area or department rules and regulations
*District Policy 4017 Nondiscrimination & 4018 Sexual Harassment
*Work schedules and options, if any, for make-up hours
*Student work assignment may be terminated for Student Code of Conduct violation and/or lack of work at any time
*That poor performance may result in reassignment
*That assignment may be terminated at any time due to lack of work

Students have the responsibility to:

*Maintain confidentiality
*Be punctual and professional
*Follow directions of supervision and/or office staff
*Contact the Supervisor immediately if enrollment drops below 6 units (Fall/Spring)/ 3 units (Summer)
*Immediately notify supervisor if unable to be on duty
*Submit Payroll Claims for supervisor approval by the 18th of each month

I have received, understand, and completed all the above documents. I understand that all documents are due in Human Resources no later than the 1st day of start of work and that failure to complete fully and sign all required documents may result in delay of pay.

Student Signature: _____ Date: _____

Yosemite Community College District
Human Resources

Student Worker Application

☐ **Modesto Junior College**
☐ **Columbia College**
☐ **YCCD**

☐ **CALWorks**
☐ **Federal WorkStudy**
☐ **Regular**

Department/Division _____ **Manager/Supervisor** _____

Colleague ID# _____ **Last Name** _____ **First Name** _____ **Middle** _____

Mailing Address _____ _____ _____ _____–
Number & Street City State Zip

Home Phone # _____ **Cell Phone #** _____ **Other #** _____

E-mail Address: _____

Units Completed _____ **Cumulative G.P.A.** _____ **Units Enrolled** _____

Have you ever been a student worker on campus? ☐ Yes ☐ No
If yes, which department/s: _____

Are you currently a student worker in another department? ☐ Yes ☐ No
If yes, in which department/s: _____

Criminal History Disclosure:

Yosemite Community College District requires all applicants to answer questions regarding their criminal history.
(Conviction of a misdemeanor or felony will not automatically eliminate applicant for a position.)

Have you ever been convicted of a misdemeanor? ☐ Yes ☐ No If yes, please explain: _____

Have you ever been convicted of a felony? ☐ Yes ☐ No If yes, please explain: _____

Do you have a Department of Justice report on file with YCCD? ☐ Yes ☐ No

I certify under penalty of perjury that all statements herein are true and correct. I understand that by disclosing a prior criminal history, I will not be assigned to a work site until a criminal history clearance and administrative approval by YCCD Human Resources are on file. Further, I understand that any fees associated with this clearance process are my responsibility. I acknowledge that fingerprinting must be completed within 10 days of start of work; unless position requires clearance prior to start of work.

_____ _____
Student Signature Date

Yosemite Community College District
Human Resources

STUDENT EMPLOYMENT CONFIRMATION

☐ Modesto Junior College
☐ Columbia College
☐ YCCD

Academic Year: _____

Summer ☐
Fall ☐
Spring ☐

Last Name: _____ First Name: _____Middle Initial: ____

Colleague ID: _____ Dept: _____ Date of Hire: _____

CONFIRMATION:

- Student is enrolled in 6 Units or more (3 Units or more for Summer).
- Student is required to complete Fingerprinting and Criminal History Background check, at the expense of the student. If the student has answered "yes" to any Criminal History Questions on the Student Worker Application, do not assign work until fingerprint clearance has been received.

Responsibility Code Manager's Signature:_____ Date: _____

Please indicate Alternate Authorized Signer to approve student pay claims/time entries if the Responsibility Code Manager above is not available: _____

Choose One of the Following:

☐ Federal Workstudy ☐ CalWORKs ☐ Regular

NOTE: Number of work hours per week may not exceed 20 hours in any one department or combination of departments.

ACCOUNT NUMBER/S:

_____ % _____

_____ % _____

_____ % _____

HR USE ONLY:

Position ID: _____

Yosemite Community College District
Human Resources

IMPORTANT NOTICE ON FINGERPRINTS

YCCD requires all new employees to undergo fingerprinting for criminal history background checks. An individual who is to be employed or volunteering in Child Care Departments, or as a Custodian, or in the Campus Safety/Security Department or if they have disclosed a misdemeanor or felony, must clear fingerprinting and background checks prior to beginning work.

Required at LIVESCAN Locations:

1) Valid picture ID (Driver's License, Passport, etc.)
2) LiveScan Submission Form (from MJC Security / Columbia Business Office)
3) Payment

COLUMBIA: Please report to Columbia College Security (209-566-5476) to pick up your LiveScan form. There is a $49.00 processing charge. Accepted payments - cash, check, credit card, Venmo, and Apple/Google pay. Make check or money order payable to YCCD.

* * * * *

LIVESCAN locations:

Tuolumne County Superintendent of Schools	By appt. Only
175 S. Fairview Ln.	Mon & Wed: 12pm – 3:30pm
Sonora	Tues, Thurs, & Fri: 10:00am – 1:00pm
209-536-2013	Cost: $23 (Exact amount for cash)

MODESTO: Please report to MJC Campus Security (575-6351) to pick up your Live Scan form. There is a $49.00 processing charge payment method: cash (exact amount) check or money orders are accepted. Make check or money order payable to YCCD. Also know your social security number, supervisor's name, and your working title.

* * * * *

LIVESCAN locations:

CSU, Stanislaus	Walk-Ins Only
801 West Monte Vista Ave	Mon & Fri 8am-3pm
Turlock	Tues, Weds, Thurs: 8am-7pm
209-667-3124	Cost: $25 cash only
Maxx 1 Security	Appointments Only
121 E Orangeburg Ste. #7	Cost: $30
Modesto	
209-499-3885	

NOTE: LiveScan may be performed with any LiveScan service provider.

Employment Eligibility Verification

Department of Homeland Security

U.S. Citizenship and Immigration Services

USCIS Form I-9

OMB No.1615-0047

Expires 07/31/2026

START HERE: Employers must ensure the form instructions are available to employees when completing this form. Employers are liable for failing to comply with the requirements for completing this form. See below and the Instructions.

ANTI-DISCRIMINATION NOTICE: All employees can choose which acceptable documentation to present for Form I-9. Employers cannot ask employees for documentation to verify information in **Section 1**, or specify which acceptable documentation employees must present for **Section 2** or Supplement B, Reverification and Rehire. Treating employees differently based on their citizenship, immigration status, or national origin may be illegal.

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

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

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

Date of Birth (mm/dd/yyyy)	U.S. Social Security Number	Employee's Email Address	Employee's Telephone Number

I am aware that federal law provides for imprisonment and/or fines for false statements, or the use of false documents, in connection with the completion of this form. I attest, under penalty of perjury, that this information, including my selection of the box attesting to my citizenship or immigration status, is true and correct.

Check one of the following boxes to attest to your citizenship or immigration status (See page 2 and 3 of the instructions.):

- ☐ 1. A citizen of the United States
- ☐ 2. A noncitizen national of the United States (See Instructions.)
- ☐ 3. A lawful permanent resident (Enter USCIS or A-Number.)
- ☐ 4. A noncitizen (other than **Item Numbers 2.** and **3.** above) authorized to work until (exp. date, if any)

If you check **Item Number 4.**, enter one of these:

USCIS A-Number	OR	Form I-94 Admission Number	OR	Foreign Passport Number and Country of Issuance

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

If a preparer and/or translator assisted you in completing Section 1, that person MUST complete the Preparer and/or Translator Certification on Page 3.

Section 2. Employer Review and Verification: Employers or their authorized representative must complete and sign Section 2 within three business days after the employee's first day of employment, and must physically examine, or examine consistent with an alternative procedure authorized by the Secretary of DHS, documentation from List A OR a combination of documentation from List B and List C. Enter any additional documentation in the Additional Information box; see Instructions.

	List A	OR	List B	AND	List C
Document Title 1					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 2 (if any)					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 3 (if any)					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					

Additional Information

☐ Check here if you used an alternative procedure authorized by DHS to examine documents.

Certification: I attest, under penalty of perjury, that (1) I have examined the documentation presented by the above-named employee, (2) the above-listed documentation appears 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.

First Day of Employment (mm/dd/yyyy):

Last Name, First Name and Title of Employer or Authorized Representative	Signature of Employer or Authorized Representative	Today's Date (mm/dd/yyyy)

Employer's Business or Organization Name	Employer's Business or Organization Address, City or Town, State, ZIP Code
Yosemite Community College District	**PO Box 4065, Modesto, Ca 95352**

For reverification or rehire, complete Supplement B, Reverification and Rehire on Page 4.

LISTS OF ACCEPTABLE DOCUMENTS

All documents containing an expiration date must be unexpired.
* Documents extended by the issuing authority are considered unexpired.
Employees may present one selection from List A or a
combination of one selection from List B and one selection from List C.
Examples of many of these documents appear in the Handbook for Employers (M-274).

LIST A Documents that Establish Both Identity and Employment Authorization	OR	LIST B Documents that Establish Identity	AND	LIST C Documents that Establish Employment Authorization
1. U.S. Passport or U.S. Passport Card		**1.** Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		**1.** A Social Security Account Number card, unless the card includes one of the following restrictions: **(1)** NOT VALID FOR EMPLOYMENT **(2)** VALID FOR WORK ONLY WITH INS AUTHORIZATION **(3)** VALID FOR WORK ONLY WITH DHS AUTHORIZATION
2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)		**2.** ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		**2.** Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240)
3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa		**3.** School ID card with a photograph		**3.** 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. Employment Authorization Document that contains a photograph (Form I-766)		**4.** Voter's registration card		**4.** Native American tribal document
5. For an individual temporarily authorized to work for a specific employer because of his or her status or parole: **a.** Foreign passport; and **b.** Form I-94 or Form I-94A that has the following: **(1)** The same name as the passport; and **(2)** An endorsement of the individual's status or parole as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form.		**5.** U.S. Military card or draft record		**5.** U.S. Citizen ID Card (Form I-197)
		6. Military dependent's ID card		**6.** Identification Card for Use of Resident Citizen in the United States (Form I-179)
		7. U.S. Coast Guard Merchant Mariner Card		**7.** Employment authorization document issued by the Department of Homeland Security For examples, see **Section 7** and **Section 13** of the M-274 on **uscis.gov/i-9-central**. The Form I-766, Employment Authorization Document, is a List A, **Item Number 4.** document, not a List C document.
		8. Native American tribal document		
		9. Driver's license issued by a Canadian government authority		
		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		
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				

Acceptable Receipts

May be presented in lieu of a document listed above for a temporary period.
For receipt validity dates, see the M-274.

• Receipt for a replacement of a lost, stolen, or damaged List A document. • Form I-94 issued to a lawful permanent resident that contains an I-551 stamp and a photograph of the individual. • Form I-94 with "RE" notation or refugee stamp issued to a refugee.	**OR**	Receipt for a replacement of a lost, stolen, or damaged List B document.	Receipt for a replacement of a lost, stolen, or damaged List C document.

*Refer to the Employment Authorization Extensions page on **I-9 Central** for more information.

Supplement A, Preparer and/or Translator Certification for Section 1

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

USCIS
Form I-9
Supplement A
OMB No. 1615-0047
Expires 07/31/2026

Last Name *(Family Name)* from **Section 1.**	First Name *(Given Name)* from **Section 1.**	Middle initial (if any) from **Section 1.**

Instructions: This supplement must be completed by any preparer and/or translator who assists an employee in completing Section 1 of Form I-9. The preparer and/or translator must enter the employee's name in the spaces provided above. Each preparer or translator must complete, sign, and date a separate certification area. Employers must retain completed supplement sheets with the employee's completed Form I-9.

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			Date *(mm/dd/yyyy)*
Last Name *(Family Name)*	First Name *(Given Name)*		Middle Initial *(if any)*
Address *(Street Number and Name)*	City or Town	State	ZIP Code

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			Date *(mm/dd/yyyy)*
Last Name *(Family Name)*	First Name *(Given Name)*		Middle Initial *(if any)*
Address *(Street Number and Name)*	City or Town	State	ZIP Code

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			Date *(mm/dd/yyyy)*
Last Name *(Family Name)*	First Name *(Given Name)*		Middle Initial *(if any)*
Address *(Street Number and Name)*	City or Town	State	ZIP Code

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			Date *(mm/dd/yyyy)*
Last Name *(Family Name)*	First Name *(Given Name)*		Middle Initial *(if any)*
Address *(Street Number and Name)*	City or Town	State	ZIP Code

Supplement B,
Reverification and Rehire (formerly Section 3)

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

USCIS
Form I-9
Supplement B
OMB No. 1615-0047
Expires 07/31/2026

Last Name *(Family Name)* from **Section 1.**	First Name *(Given Name)* from **Section 1.**	Middle initial (if any) from **Section 1.**

Instructions: This supplement replaces Section 3 on the previous version of Form I-9. Only use this page if your employee requires reverification, is rehired within three years of the date the original Form I-9 was completed, or provides proof of a legal name change. Enter the employee's name in the fields above. Use a new section for each reverification or rehire. Review the Form I-9 instructions before completing this page. Keep this page as part of the employee's Form I-9 record. Additional guidance can be found in the Handbook for Employers: Guidance for Completing Form I-9 (M-274)

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

Reverification: If the employee requires reverification, your employee can choose to present any acceptable List A or List C documentation to show continued employment authorization. Enter the document information in the spaces below.

Document Title	Document Number (if any)	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 documentation, the documentation I examined appears to be genuine and to relate to the individual who presented it.

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

Additional Information (Initial and date each notation.)

☐ Check here if you used an alternative procedure authorized by DHS to examine documents.

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

Reverification: If the employee requires reverification, your employee can choose to present any acceptable List A or List C documentation to show continued employment authorization. Enter the document information in the spaces below.

Document Title	Document Number (if any)	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 documentation, the documentation I examined appears to be genuine and to relate to the individual who presented it.

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

Additional Information (Initial and date each notation.)

☐ Check here if you used an alternative procedure authorized by DHS to examine documents.

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

Reverification: If the employee requires reverification, your employee can choose to present any acceptable List A or List C documentation to show continued employment authorization. Enter the document information in the spaces below.

Document Title	Document Number (if any)	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 documentation, the documentation I examined appears to be genuine and to relate to the individual who presented it.

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

Additional Information (Initial and date each notation.)

☐ Check here if you used an alternative procedure authorized by DHS to examine documents.

Yosemite Community College District
Human Resources

OATH OF AFFIRMATION

PART 1 – OATH OF ALLEGIANCE
TO BE COMPLETED BY UNITED STATES CITIZENS ONLY

By Virtue of the provisions of Section 3107 of the Government Code, no compensation or reimbursement for expense incurred may be paid to a school district employee unless the employee has taken or subscribed to the oath or affirmation set below, prior to entering upon the duties of his/her employment.

I, (Employee Name) _____, 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.

PART 2 – DECLARATION OF PERMISSION TO WORK
TO BE COMPLETED BY LEGALLY EMPLOYED NONCITIZENS ONLY

As required in Section 3 of Article XX of the Constitution of the State of California every State employee except legally employed noncitizens, must sign the following oath or affirmation before he or she enters upon the duties of his or her State employment. Noncitizens are required to possess a Declaration of Permission to Work. If a alien employee becomes a naturalize citizen an oath must then be obtained and filed.

I am a lawful permanent resident alien of the United States. ☐ Yes ☐ No

If **NO**, please read the following:

I hereby certify, that I have permission to work in this country and have declared any restrictions placed upon me in this regards by the United States government to the appointing power.

PART 3 – SIGNATURE AND CERTIFICATION
(*Notary Not Required)*

_____ _____
(Employee Signature) (Employee Printed Name)

For Office Use Only

Subscribed and sworn (affirmed) to/before me this _____ day of _____, 20___

_____
Signature of YCCD Official

_____
Title

Government Code 3100-3107

Yosemite Community College District
Human Resources

Policy Acknowledgement

Please read the policies/procedures carefully to ensure that you understand the policy before signing this document.

The Yosemite Community College District Board Policies and Procedures contain important information pertaining to my employment at Yosemite Community College District. I understand that if I have questions, at any time, regarding the policies/procedures, I will consult with my immediate supervisor or my Human Resources staff members.

I have read and been informed about the content, requirements, and expectations of the policies/procedures at Yosemite Community College District. I agree to abide by the guidelines as a condition of my employment and my continuing employment at Yosemite Community College District.

Since the information described in the policies and procedures are necessarily subject to change, I acknowledge that revisions to the policies/procedures may occur. All such changes will be communicated through official notices. I understand the revised information may supersede, modify, or eliminate existing policies.

Furthermore, I acknowledge that the policies and procedures are neither a contract of employment nor a legal document. I understand this manual is not intended to cover every situation that may arise during my employment, but is simply a general guide to the goals, policies, practices, benefits, and expectations of Yosemite Community College District.

1100	The Yosemite Community College District
1200	District Mission
3050	Institutional Code of Ethics
3410	Non-Discrimination
3420	Equal Employment Opportunity
3430	Prohibition of Harassment
3435	Discrimination and Harassment Complaints and Investigations
3505	Emergency Response Plan
3510	Workplace Violence
3515	Reporting of Crimes
3518	Child Abuse
3530	Weapons on Campus
3540	Sex/Gender Harassment, Discrimination and Sexual Misconduct
3550	Drug Free Environment and Drug Prevention Program
3560	Alcoholic Beverages, Intoxicants and Narcotics
3720	Computer and Network Use
3900	Time, Place, Manner
6530	Authorization to Drive District Vehicles
6535	Use of District Equipment
6800	Safety
7100	Commitment to Diversity
7310	Nepotism
7330	Communicable Disease
7335	Health Examinations
7336	Certification of Freedom from Tuberculosis
7340	Leaves
7365	Discipline and Dismissal - Classified Employees
7400	Staff Travel
7700	Whistleblower Protection
7-8037	Duties of Employees
7-8052	Dismissal
7-8057	Civility
7-8058	Non-Discrimination (Equal Opportunity)

All District Policies/Procedures can be reviewed at https://www.yosemite.edu/trustees/boardpolicy.

Employees Name (Print): _____

Employee's Signature: _____ Date: _____

Yosemite Community College District
Human Resources

CONFIDENTIALITY STATEMENT FOR STUDENT WORKERS

Name of Student Employee (print please) _____

Department/Division _____

READ CAREFULLY:

We are happy that you are joining the _____ (*designated office*) team. As you may already know, our work encompasses many areas of student and campus life, including the gathering, upkeep and storage of records, applications and other information that is highly confidential.

Material that is confidential is "imparted in confidence; secret; having to do with private matters". In other words, we have been entrusted by students, your unit's employees, Modesto Jr. College, Columbia College and the YCCD, with private information in order to better serve them and our community. This material does not belong to us; it belongs to the people who have entrusted it to us. **We are not free to share any of the content of this material, or the names or any other information about the persons, units, departments or divisions to whom it belongs or about whom it is written or concerns.** This means that we must not speak of this material to anyone but authorized person, and then, only when we are working with those persons on m atters pertaining to this material. Even when working with confidential documents in an official capacity, it is important that we to not speak of them or leave them in areas where unauthorized persons may overhear related discussions or read these materials. **It is not ok to discuss this material** with other employees during lunch or breaks, nor it is acceptable to speak about them in classes or at home with your family and friends. It is also important that you realize that **once you are no longer employed as an MJC or CC or YCCD employee, or after you leave these entities, you are not at that point free to divulge to anyone information that you used or learned while you were working here.**

I, _____ (*printed name*), have read the above concerning the importance of confidentiality in my work for MJC/CC/YCCD, and **I agree to keep private and secret confidential material entrusted to me.** This means that I will not disclose this material inappropriately either during or after my working hours, nor after I leave the employment of MJC/CC/YCCD. I understand that if I violate this agreement, I may be dismissed, and a notation regarding the reason for my dismissal will be entered in my employment record.

Student Employee Signature: _____ Date: _____

Manager's Signature: __ _____ Date: _____

Yosemite Community College District
Human Resources

EMERGENCY CONTACT INFORMATION

_____ _____ _____
Print Employee Name | Colleague ID # | Date of Birth

_____ _____ _____
Street Address (No PO Boxes) | City | Zip

At: ☐ MJC ☐ CC ☐ YCCD Department: _____ Phone#: _____

Check all that apply: ☐ Student ☐ Short-Term ☐ Part-Time Faculty
☐ Classified ☐ Faculty ☐ Mgmt/Admin

In Case of Emergency, please notify the following:

1. _____ _____
Name | Relationship

_____ _____ _____
Daytime Number | Evening Number | Cell Number

2. _____ _____
Name | Relationship

_____ _____ _____
Daytime Number | Evening Number | Cell Number

3. _____ _____
Name | Relationship

_____ _____ _____
Daytime Number | Evening Number | Cell Number

_____ _____
Signature | Date

Please return your completed form to the Human Resources Office.
This information will be kept in your Personnel File.

Form **W-4**

Department of the Treasury
Internal Revenue Service

Employee's Withholding Certificate

Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay.
Give Form W-4 to your employer.
Your withholding is subject to review by the IRS.

OMB No. 1545-0074

2025

Step 1: Enter Personal Information

(a) First name and middle initial	Last name	(b) Social security number
Address		**Does your name match the name on your social security card?** If not, to ensure you get credit for your earnings, contact SSA at 800-772-1213 or go to *www.ssa.gov*.
City or town, state, and ZIP code		

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

TIP: Consider using the estimator at *www.irs.gov/W4App* to determine the most accurate withholding for the rest of the year if: you are completing this form after the beginning of the year; expect to work only part of the year; or have changes during the year in your marital status, number of jobs for you (and/or your spouse if married filing jointly), dependents, other income (not from jobs), deductions, or credits. Have your most recent pay stub(s) from this year available when using the estimator. At the beginning of next year, use the estimator again to recheck your withholding.

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, and when to use the estimator at *www.irs.gov/W4App*.

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 the most accurate withholding for this step (and Steps 3–4). If you or your spouse have self-employment income, use this option; **or**

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

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

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 Dependent and Other Credits

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

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

Multiply the number of other dependents by $500 . . . . . $ _____

Add the amounts above for qualifying children and other dependents. You may add to this the amount of any other credits. Enter the total here . . . . . **3** $

Step 4 (optional): Other Adjustments

(a) Other income (not from jobs). If you want tax withheld for other income you expect this year that won't have withholding, enter the amount of other income here. This may include interest, dividends, and retirement income . . . . . **4(a)** $

(b) Deductions. If you expect to claim deductions other than the standard deduction and want to reduce your withholding, use the Deductions Worksheet on page 3 and enter the result here . . . . . **4(b)** $

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

Step 5: Sign Here

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

Employee's signature (This form is not valid unless you sign it.) **Date**

Employers Only

Employer's name and address	First date of employment	Employer identification number (EIN)

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Future Developments

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

Purpose of Form

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

Exemption from withholding. You may claim exemption from withholding for 2025 if you meet both of the following conditions: you had no federal income tax liability in 2024 **and** you expect to have no federal income tax liability in 2025. You had no federal income tax liability in 2024 if (1) your total tax on line 24 on your 2024 Form 1040 or 1040-SR is zero (or less than the sum of lines 27, 28, and 29), or (2) you were not required to file a return because your income was below the filing threshold for your correct filing status. If you claim exemption, you will have no income tax withheld from your paycheck and may owe taxes and penalties when you file your 2025 tax return. To claim exemption from withholding, certify that you meet both of the conditions above by writing "Exempt" on Form W-4 in the space below Step 4(c). Then, complete Steps 1(a), 1(b), and 5. Do not complete any other steps. You will need to submit a new Form W-4 by February 17, 2026.

Your privacy. Steps 2(c) and 4(a) ask for information regarding income you received from sources other than the job associated with this Form W-4. If you have concerns with providing the information asked for in Step 2(c), you may choose Step 2(b) as an alternative; if you have concerns with providing the information asked for in Step 4(a), you may enter an additional amount you want withheld per pay period in Step 4(c) as an alternative.

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

1. Are submitting this form after the beginning of the year;

2. Expect to work only part of the year;

3. Have changes during the year in your marital status, number of jobs for you (and/or your spouse if married filing jointly), or number of dependents, or changes in your deductions or credits;

4. Receive dividends, capital gains, social security, bonuses, or business income, or are subject to the Additional Medicare Tax or Net Investment Income Tax; or

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

TIP: Have your most recent pay stub(s) from this year available when using the estimator to account for federal income tax that has already been withheld this year. At the beginning of next year, use the estimator again to recheck your withholding.

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. Submit a separate Form W-4 for each job.

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

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

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

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

Step 4 (optional).

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

Step 4(b). Enter in this step the amount from the Deductions Worksheet, line 5, if you expect to claim deductions other than the basic standard deduction on your 2025 tax return and want to reduce your withholding to account for these deductions. This includes both itemized deductions and other deductions such as for student loan interest and IRAs.

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

Step 2(b)—Multiple Jobs Worksheet *(Keep for your records.)*

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

Note: If more than one job has annual wages of more than $120,000 or there are more than three jobs, see Pub. 505 for additional tables; 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 2025 itemized deductions (from Schedule A (Form 1040)). Such deductions may include qualifying home mortgage interest, charitable contributions, state and local taxes (up to $10,000), and medical expenses in excess of 7.5% of your income . . . . . 1 $

2 Enter:
- $30,000 if you're married filing jointly or a qualifying surviving spouse
- $22,500 if you're head of household
- $15,000 if you're single or married filing separately

. . . . . 2 $

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

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

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

Privacy Act and Paperwork Reduction Act Notice. We ask for the information on this form to carry out the Internal Revenue laws of the United States. Internal Revenue Code sections 3402(f)(2) and 6109 and their regulations require you to provide this information; your employer uses it to determine your federal income tax withholding. Failure to provide a properly completed form will result in your being treated as a single person with no other entries on the form; providing fraudulent information may subject you to penalties. Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation; to cities, states, the District of Columbia, and U.S. commonwealths and territories for use in administering their tax laws; and to the Department of Health and Human Services for use in the National Directory of New Hires. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

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

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

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

Married Filing Jointly or Qualifying Surviving Spouse

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	$0	$700	$850	$910	$1,020	$1,020	$1,020	$1,020	$1,020	$1,020	$1,020
$10,000 - 19,999	0	700	1,700	1,910	2,110	2,220	2,220	2,220	2,220	2,220	2,220	3,220
$20,000 - 29,999	700	1,700	2,760	3,110	3,310	3,420	3,420	3,420	3,420	3,420	4,420	5,420
$30,000 - 39,999	850	1,910	3,110	3,460	3,660	3,770	3,770	3,770	3,770	4,770	5,770	6,770
$40,000 - 49,999	910	2,110	3,310	3,660	3,860	3,970	3,970	3,970	4,970	5,970	6,970	7,970
$50,000 - 59,999	1,020	2,220	3,420	3,770	3,970	4,080	4,080	5,080	6,080	7,080	8,080	9,080
$60,000 - 69,999	1,020	2,220	3,420	3,770	3,970	4,080	5,080	6,080	7,080	8,080	9,080	10,080
$70,000 - 79,999	1,020	2,220	3,420	3,770	3,970	5,080	6,080	7,080	8,080	9,080	10,080	11,080
$80,000 - 99,999	1,020	2,220	3,420	4,620	5,820	6,930	7,930	8,930	9,930	10,930	11,930	12,930
$100,000 - 149,999	1,870	4,070	6,270	7,620	8,820	9,930	10,930	11,930	12,930	14,010	15,210	16,410
$150,000 - 239,999	1,870	4,240	6,640	8,190	9,590	10,890	12,090	13,290	14,490	15,690	16,890	18,090
$240,000 - 259,999	2,040	4,440	6,840	8,390	9,790	11,100	12,300	13,500	14,700	15,900	17,100	18,300
$260,000 - 279,999	2,040	4,440	6,840	8,390	9,790	11,100	12,300	13,500	14,700	15,900	17,100	18,300
$280,000 - 299,999	2,040	4,440	6,840	8,390	9,790	11,100	12,300	13,500	14,700	15,900	17,100	18,300
$300,000 - 319,999	2,040	4,440	6,840	8,390	9,790	11,100	12,300	13,500	14,700	15,900	17,170	19,170
$320,000 - 364,999	2,040	4,440	6,840	8,390	9,790	11,100	12,470	14,470	16,470	18,470	20,470	22,470
$365,000 - 524,999	2,790	6,290	9,790	12,440	14,940	17,350	19,650	21,950	24,250	26,550	28,850	31,150
$525,000 and over	3,140	6,840	10,540	13,390	16,090	18,700	21,200	23,700	26,200	28,700	31,200	33,700

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	$200	$850	$1,020	$1,020	$1,020	$1,370	$1,870	$1,870	$1,870	$1,870	$1,870	$2,040
$10,000 - 19,999	850	1,700	1,870	1,870	2,220	3,220	3,720	3,720	3,720	3,720	3,890	4,090
$20,000 - 29,999	1,020	1,870	2,040	2,390	3,390	4,390	4,890	4,890	4,890	5,060	5,260	5,460
$30,000 - 39,999	1,020	1,870	2,390	3,390	4,390	5,390	5,890	5,890	6,060	6,260	6,460	6,660
$40,000 - 59,999	1,220	3,070	4,240	5,240	6,240	7,240	7,880	8,080	8,280	8,480	8,680	8,880
$60,000 - 79,999	1,870	3,720	4,890	5,890	7,030	8,230	8,930	9,130	9,330	9,530	9,730	9,930
$80,000 - 99,999	1,870	3,720	5,030	6,230	7,430	8,630	9,330	9,530	9,730	9,930	10,130	10,580
$100,000 - 124,999	2,040	4,090	5,460	6,660	7,860	9,060	9,760	9,960	10,160	10,950	11,950	12,950
$125,000 - 149,999	2,040	4,090	5,460	6,660	7,860	9,060	9,950	10,950	11,950	12,950	13,950	14,950
$150,000 - 174,999	2,040	4,090	5,460	6,660	8,450	10,450	11,950	12,950	13,950	15,080	16,380	17,680
$175,000 - 199,999	2,040	4,290	6,450	8,450	10,450	12,450	13,950	15,230	16,530	17,830	19,130	20,430
$200,000 - 249,999	2,720	5,570	7,900	10,200	12,500	14,800	16,600	17,900	19,200	20,500	21,800	23,100
$250,000 - 399,999	2,970	6,120	8,590	10,890	13,190	15,490	17,290	18,590	19,890	21,190	22,490	23,790
$400,000 - 449,999	2,970	6,120	8,590	10,890	13,190	15,490	17,290	18,590	19,890	21,190	22,490	23,790
$450,000 and over	3,140	6,490	9,160	11,660	14,160	16,660	18,660	20,160	21,660	23,160	24,660	26,160

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	$450	$850	$1,000	$1,020	$1,020	$1,020	$1,020	$1,870	$1,870	$1,870	$1,890
$10,000 - 19,999	450	1,450	2,000	2,200	2,220	2,220	2,220	3,180	4,070	4,070	4,090	4,290
$20,000 - 29,999	850	2,000	2,600	2,800	2,820	2,820	3,780	4,780	5,670	5,690	5,890	6,090
$30,000 - 39,999	1,000	2,200	2,800	3,000	3,020	3,980	4,980	5,980	6,890	7,090	7,290	7,490
$40,000 - 59,999	1,020	2,220	2,820	3,830	4,850	5,850	6,850	8,050	9,130	9,330	9,530	9,730
$60,000 - 79,999	1,020	3,030	4,630	5,830	6,850	8,050	9,250	10,450	11,530	11,730	11,930	12,130
$80,000 - 99,999	1,870	4,070	5,670	7,060	8,280	9,480	10,680	11,880	12,970	13,170	13,370	13,570
$100,000 - 124,999	1,950	4,350	6,150	7,550	8,770	9,970	11,170	12,370	13,450	13,650	14,650	15,650
$125,000 - 149,999	2,040	4,440	6,240	7,640	8,860	10,060	11,260	12,860	14,740	15,740	16,740	17,740
$150,000 - 174,999	2,040	4,440	6,240	7,640	8,860	10,860	12,860	14,860	16,740	17,740	18,940	20,240
$175,000 - 199,999	2,040	4,440	6,640	8,840	10,860	12,860	14,860	16,910	19,090	20,390	21,690	22,990
$200,000 - 249,999	2,720	5,920	8,520	10,960	13,280	15,580	17,880	20,180	22,360	23,660	24,960	26,260
$250,000 - 449,999	2,970	6,470	9,370	11,870	14,190	16,490	18,790	21,090	23,280	24,580	25,880	27,180
$450,000 and over	3,140	6,840	9,940	12,640	15,160	17,660	20,160	22,660	25,050	26,550	28,050	29,550

Employment Development Department
State of California

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 ZIP Code	Filing Status ☐ Single or Married (with two or more incomes) ☐ Married (one income) ☐ Head of Household

1. Use Worksheet A for Regular Withholding allowances. Use other worksheets on the following pages as applicable.
   1a. Number of Regular Withholding Allowances (**Worksheet A**)
   1b. Number of allowances from the Estimated Deductions (**Worksheet B**, if applicable.)
   1c. Total Number of Allowances you are claiming
2. Additional amount, if any, you want withheld each pay period (if employer agrees), **(Worksheet C)**
   OR

Exemption from Withholding

3. I claim exemption from withholding for 2024, and I certify I meet both of the conditions for exemption. (Check box here) ☐
   OR
4. I certify under penalty of perjury that I am **not subject** to California withholding. I meet the conditions set forth under the Service Member Civil Relief Act, as amended by the Military Spouses Residency Relief Act and the Veterans Benefits and Transition Act of 2018. (Check box here) ☐

Under the penalties of perjury, I certify that the number of withholding allowances claimed on this certificate does not exceed the number to which I am entitled or, if claiming exemption from withholding, that I am entitled to claim the exempt status.

Employee's Signature _____ Date _____

Employer's Section: Employer's Name and Address	California Employer Payroll Tax Account Number
Yosemite Community College District PO Box 4065 Modesto, CA 95352	80292691

Purpose: The *Employee's Withholding Allowance 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 DE 4 to determine the appropriate California PIT withholding.

If you do not provide your employer with a DE 4, the employer must use Single with Zero withholding allowance.

Check Your Withholding: After your DE 4 takes effect, compare the state income tax withheld with your estimated total annual tax. For state withholding, use the worksheets on this form.

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

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

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

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

(i) Your spouse is a member of the armed forces present in California in compliance with military orders;

(ii) You are present in California solely to be with your spouse; and

(iii) You maintain your domicile in another state.

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

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

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

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

Penalty: You may be fined $500 if you file, with no reasonable basis, a DE 4 that results in less tax being withheld than is properly allowable. In addition, criminal penalties apply for willfully supplying false or fraudulent information or failing to supply information requiring an increase in withholding. This is provided by section 13101 of the California Unemployment Insurance Code (leginfo.legislature.ca.gov/faces/codes.xhtml) and section 19176 of the Revenue and Taxation Code (leginfo.legislature.ca.gov/faces/codes.xhtml).

Worksheets

Instructions — 1 — Allowances*

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

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

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

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

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

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

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 $10,726 if married filing joint with two or more allowances, unmarried head of household, or qualifying widow(er) with dependent(s) or $5,363 if single or married filing separately, dual income married, or married with multiple employers	–	2.
3.	Subtract line 2 from line 1, enter difference	=	3.
4.	Enter an estimate of your adjustments to income (alimony payments, IRA deposits)	+	4.
5.	Add line 4 to line 3, enter sum	=	5.
6.	Enter an estimate of your nonwage income (dividends, interest income, alimony receipts)	–	6.
7.	If line 5 is greater than line 6 (if less, see below [go to line 9]); Subtract line 6 from line 5, enter difference	=	7.
8.	Divide the amount on line 7 by $1,000, round any fraction to the nearest whole number enter this number on line 1b of the DE 4. Complete Worksheet C, if needed, otherwise **stop here**.		8.
9.	If line 6 is greater than line 5; Enter amount from line 6 (nonwage income)		9.
10.	Enter amount from line 5 (deductions)		10.
11.	Subtract line 10 from line 9, enter difference. Then, complete Worksheet C.		11.

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

Worksheet C **Additional Tax Withholding and Estimated Tax**

1.	Enter estimate of total wages for tax year 2024.	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 2024 tax rate schedules below.	8.
9.	Enter personal exemptions (line F of Worksheet A x $158.40).	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 2024. 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 2024. 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 2024.	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 2024 Only

Single Persons, Dual Income Married or Married With Multiple Employers

IF THE TAXABLE INCOME IS		COMPUTED TAX IS		
OVER	BUT NOT OVER	OF AMOUNT OVER...		PLUS
$0	$10,412	1.100%	$0	$0.00
$10,412	$24,684	2.200%	$10,412	$114.53
$24,684	$38,959	4.400%	$24,684	$428.51
$38,959	$54,081	6.600%	$38,959	$1,056.61
$54,081	$68,350	8.800%	$54,081	$2,054.66
$68,350	$349,137	10.230%	$68,350	$3,310.33
$349,137	$418,961	11.330%	$349,137	$32,034.84
$418,961	$698,271	12.430%	$418,961	$39,945.90
$698,271	$1,000,000	13.530%	$698,271	$74,664.13
$1,000,000	and over	14.630%	$1,000,000	$115,488.06

Unmarried/Head of Household

IF THE TAXABLE INCOME IS		COMPUTED TAX IS		
OVER	BUT NOT OVER	OF AMOUNT OVER...		PLUS
$0	$20,839	1.100%	$0	$0.00
$20,839	$49,371	2.200%	$20,839	$229.23
$49,371	$63,644	4.400%	$49,371	$856.93
$63,644	$78,765	6.600%	$63,644	$1,484.94
$78,765	$93,037	8.800%	$78,765	$2,482.93
$93,037	$474,824	10.230%	$93,037	$3,738.87
$474,824	$569,790	11.330%	$474,824	$42,795.68
$569,790	$949,649	12.430%	$569,790	$53,555.33
$949,649	$1,000,000	13.530%	$949,649	$100,771.80
$1,000,000	and over	14.630%	$1,000,000	$107,584.29

Married Persons

IF THE TAXABLE INCOME IS		COMPUTED TAX IS		
OVER	BUT NOT OVER	OF AMOUNT OVER...		PLUS
$0	$20,824	1.100%	$0	$0.00
$20,824	$49,368	2.200%	$20,824	$229.06
$49,368	$77,918	4.400%	$49,368	$857.03
$77,918	$108,162	6.600%	$77,918	$2,113.23
$108,162	$136,700	8.800%	$108,162	$4,109.33
$136,700	$698,274	10.230%	$136,700	$6,620.67
$698,274	$837,922	11.330%	$698,274	$64,069.69
$837,922	$1,000,000	12.430%	$837,922	$79,891.81
$1,000,000	$1,396,542	13.530%	$1,000,000	$100,038.11
$1,396,542	and over	14.630%	$1,396,542	$153,690.24

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

The DE 4 information is collected for purposes of administering the PIT law and under the authority of Title 22, CCR, section 4340-1, and the California Revenue and Taxation Code, including section 18624. The Information Practices Act of 1977 requires that individuals be notified of how information they provide may be used. Further information is contained in the instructions that came with your last California resident income tax return.

State of California
California Public Employees' Retirement System
www.calpers.ca.gov

Notice of Exclusion from CalPERS Membership

Public Agency and Schools

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

Section 1: Employee Information

Last Name	First	Middle	DOB	CID

Section 2: Employer Information

Name of Department	Division	Position Title

Term of Appointment: ☐ **Permanent** ☒ **Temporary**

If Temporary, enter nearest number of whole months the appointment is expected to last: **Months** **Appointment Date**

Time Base: ☐ **Full Time** ☐ **Intermittent**

☐ **Indeterminate** ☒ **Part Time** if part time enter the fraction of full time:

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

1. ☐ Your full time seasonal or limited term appointment is limited to six months or less.
2. ☐ Your part time appointment is limited to less than an average of 20 hours per week for less than one year.
3. ☐ Your appointment is an on call, intermittent, emergency, substitute, or other irregular basis which excludes you from membership until you have worked 1,000 hours (or 125 days if paid on per diem basis) in a fiscal year (July 1-June 30).
4. ☐ Your position is excluded by law. Explain the exclusion that applies below:

5. ☐ You are an independent contractor.
6. ☐ You are employed to render professional legal service to a city. Exceptions include persons holding the office of city attorney, deputy city attorney, or assistant city attorney.
7. ☐ You are employed as a student assistant by a school district in a position established for students only while attending school in the same district. (This only applies to County Schools.)
8. ☐ You are a CalPERS retiree and have not reinstated from retirement.
   Note: If you are a CalPERS member from previous employment and have not terminated membership (taken a refund of your contributions and service credit) exclusions 1, 2, and 3 do not apply to you. You should qualify for membership immediately in your current position. Please notify your employer to complete your enrollment and report your employment to CalPERS.

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

Signature of Certifying Officer	**Title**	**Date**

Signature of Employee	**Date**

Note: Information regarding the benefits provided by CalPERS is available on the CalPERS website www.calpers.ca.gov.

The employer must retain this form in the employee's file for auditing purposes.

CalPERS Privacy Notice

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

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

Please do not include information that is not requested.

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

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

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

Your Rights
You have the right to review your membership files maintained by CalPERS. For questions about this notice, our Privacy Policy, or your rights, write to:

CalPERS
CalPERS Privacy Officer
400 Q Street
Sacramento, CA 95811

You may also call us at **888 CalPERS** (or **888**-225-7377).

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

Employee Name _____ **Employee ID#** _____

Employer Name **Yosemite Community College District** **Employer ID#** _____

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

Windfall Elimination Provision

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

Government Pension Offset Provision

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

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

For More Information

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

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

Signature of Employee _____ **Date** _____

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

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

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

Employers must:

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

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

Copies of the SSA-1945 are available online at the Social Security website, www.socialsecurity.gov/online/ssa-1945.pdf. 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.

PAYROLL DIRECT DEPOSIT AUTHORIZATION

Mail to YCCD-Payroll Dept
PO Box 4065
Modesto, CA 95352

It may take up to 3 payroll cycles for direct deposit to go into effect. During the first cycle and possibly the second cycle you will receive a check in the mail, sent to the address you have on file with Human Resources. You must attach a voided check or a print out from your banking institution stating your name, routing number, account number, and type of account. A deposit slip is not acceptable. **Failure to follow these instructions will result in denial of your request, and it will be sent back to you unprocessed.**

Last Name First Name MI

EMPLOYEE ID # Work Phone

Action Effective Date

New Change Cancel

Your banking institution must have a physical branch in CA per Labor Code 212,213.

Financial Institution

Account Number ☑ Checking ☐ Savings

Transit Routing Number Amount

Click here if the balance of the payment is to be deposited to this account

Additional Accounts (if deposit is to be made to multiple accounts)

Financial Institution

Account Number ☑ Checking ☐ Savings

Transit Routing Number Amount

Click here if the balance of the payment is to be deposited to this account

Additional Accounts (if deposit is to be made to multiple accounts)

Financial Institution

Account Number ☑ Checking ☐ Savings

Transit Routing Number Amount

Click here if the balance of the payment is to be deposited to this account

I hereby authorize YCCD to deposit and the financial institution listed below to deposit my pay automatically to my account listed above each payday and, if necessary, to adjust or reverse a deposit for any payroll entry made to my account in error. This authorization will remain in effect until I have cancelled it in writing and with such time as to afford YCCD a reasonable opportunity to act on it. YCCD can initiate termination of this agreement based on employment circumstances that may result in overpayment or due to rejection by your financial institution.

_____ _____

Signature Date

Yosemite Community College District
Human Resources

Your Health Coverage Options & Covered California

The intent of this document is to provide general, not specific, information regarding the provisions of Affordable Care Act (ACA). It should not be construed as, nor is it intended to provide, legal or financial advice.

As a part of the Affordable Care Act (ACA) that was passed in 2010, employers are required to provide this notice to all employees regardless of whether or not they are eligible to participate in Employment-Based Health Plans.

Under the ACA, beginning January 1, 2014 individuals will be required to have minimum essential health coverage, or else be subject to a penalty. This is referred to as the "individual mandate." The Health Insurance Marketplace is intended to help individuals meet the individual mandate requirement by providing another place to purchase coverage, and possibly qualify for federal assistance to do so. Information and details are available at HealthCare.gov

In California, the Health Insurance Marketplace is called "Covered California." To assist you as you evaluate options for you and your family, this notice provides some basic information about Covered California and employment based health coverage offered by Yosemite Community College District, Employer Identification Number (EIN): 52-1566989.

Covered California is designed to help you find health insurance that meets your needs and fits your budget. Covered California 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. You are not required to purchase health coverage through Covered California, and may obtain health coverage from other sources.

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 are eligible for depends on your household income.

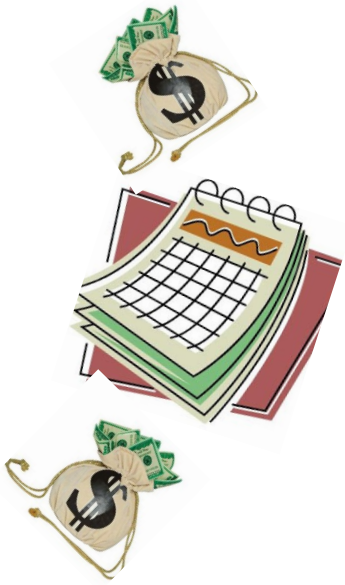
If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through Covered California and may wish to enroll in your employer's health plan, if you are eligible. (Just because you received this notice does not mean you are eligible for the Yosemite Community College District 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 your cost for self-only coverage under the Yosemite Community College District health plan 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. 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 cost.

Note: If you purchase a health plan through Covered California 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 (if any) to employer-offered coverage - is often excluded from income for Federal and State income tax purposes. Your payments for coverage through Covered California are made on an after-tax basis.

For more information about coverage offered through Covered California please visit www.coveredca.com. Covered California can help you evaluate your coverage options, including your eligibility for coverage through Covered California and its cost. You will also be able to obtain an online application for health insurance coverage. If you decide to complete an application for coverage through Covered California, you will be asked to provide certain information about the health coverage offered by Yosemite Community College District. You can obtain this information by contacting the individual listed above.

For more information about coverage offered by Yosemite Community College District, please check your summary plan description or contact: yccdbenefits@yosemite.edu , 2201 Blue Gum Avenue Phone: (209)575-6981.

When will I get paid?



Full-Time Faculty

Full-Time Classified Staff

Managers/Administrators

Payday

The last working day in the month. *Exception: employees do not receive a check in December; it is paid on the first working day in January each year.*

Pay Period

Runs from the 1st of the month through the last day of the month.
Example: 9/1/24 - 9/30/24; paid 9/30/24

Part-Time Faculty/Overload

Part-Time Classified Hourly & Short-Term

Community Lifelong Learning

Stipends

Payday

The 10th of the month, unless the 10th falls on a closure day. Example: if the 10th of the month falls on a weekend, the Friday before that weekend is the payday. If the 10th of the month falls on a holiday or a Friday during summer session, payday will be the day before.

Pay Period

Runs from the 1st of the month through the last working day in the month.

Example: 9/1/24 - 9/30/24, paid 10/10/24

Students

Payday

The 10th of the month, unless the 10th falls on a closure day. Example: if the 10th of the month falls on a weekend, the Friday before that weekend is the payday. If the 10th of the month falls on a holiday or a Friday during summer session, payday will be the day before.

Pay Period

The 16th of the month through the 15th of the next month. Example: 8/16/24 - 9/15/24, paid 10/10/24

NOTE: Self Service time entries and/or Pay Claims are due to Payroll on the 18th of each month.

Go to the Payroll Homepage at
https://www.yosemite.edu/payroll/
for more information.

NOTE: Information is available for Health and/or Dependent Care FSA. You only have 60 days from date of hire to enroll for the current calendar year.

THE FACTS ABOUT WORKERS' COMPENSATION

Yosemite Community College District

YCCD

ATHENS
People, Powered.

PO Box 696
Concord, CA 94522-0696
925-482-3535

Revised 2/01/2024 and effective for dates of injuries on or after 1/1/13.

Approved by the Division of Workers' Compensation

This pamphlet, or a similar one that has been approved by the Administrative Director, must be given to all newly hired employees in the State of California. Employers and claims administrators may use the content of this document and put their logos and additional information on it. The content of this pamphlet applies to all industrial injuries that occur on or after January 1, 2013.

WHAT IS WORKERS' COMPENSATION?

If you get hurt on the job, your employer is required by law to pay for workers' compensation benefits. You could get hurt by:

One event at work. Examples: hurting your back in a fall, getting burned by a chemical that splashes on your skin or getting hurt in a car accident while making deliveries.

OR

Repeated exposures at work. Examples: hurting your hand, back, or other part of your body from doing the same repeated motion or losing your hearing because of constant loud noise

OR

Workplace crime. Examples: you get hurt in a store robbery, physically attacked by an unhappy customer.

DISCRIMINATION IS ILLEGAL

It is illegal under Labor Code section 132a for your employer to punish or fire you because you:

- File a workers' compensation claim
- Intend to file a workers' compensation claim
- Settle a workers' compensation claim
- Testify or intend to testify for another injured worker.

If it is found that your employer discriminated against you, he or she may be ordered to return you to your job. Your employer may also be made to pay for lost wages, increased workers' compensation benefits, and costs and expenses set by state law.

WHAT ARE THE BENEFITS?

Medical care: Paid for by your employer to help you recover from an injury or illness caused by work. Doctor visits, hospital services, physical therapy, lab tests and x-rays are some of the medical services that may be provided. These services should be necessary to treat your injury. There are limits on some services such as physical and occupational therapy and chiropractic care.

Temporary Disability (TD) benefits: Payments if you lose wages because your injury prevents you from doing your usual job while recovering. The amount you may get is up to two- thirds of your wages. There are minimum and maximum payment limits set by state law. You will be paid every two weeks if you are eligible. For most injuries, payments may not exceed **104 weeks within five years from your date of injury**. Temporary Disability (TD) stops when you return to work, or when the doctor releases you for work, or says your injury has improved as much as it's going to.

Permanent Disability (PD) benefits: Payments if you don't recover completely. You will be paid every two weeks if you are eligible. There are minimum and maximum weekly payment rates established by state law. The amount of payment is based on:

- Your doctor's medical reports
- Your age
- Your occupation

Supplemental Job Displacement Benefits (SJDB): This is a voucher for up to $6,000 that you can use for retraining or skill enhancement at an approved school, books, tools, licenses or certification fees, or other resources to help you find a new job. You are eligible for this voucher if:

- You have a permanent disability.
- Your employer does not offer regular, modified, or alternative work, **within 60 days** after the claims administrator receives a doctor's report saying you have made a maximum medical recovery.

Return-to-Work Supplemental Program (RTWSP): For dates of injury after 1/1/2013, you may qualify for additional money from the Division of Workers' compensation program known as the Return-to-Work Supplement Program (RTWSP) if you received the Supplemental Job Displacement Voucher (SJDB). If you have questions or think you qualify, contact the Information & Assistance Unit by calling 1-800-736-7401 or visit website: https://www.dir.ca.gov/RTWSP/RTWSP.html

Death benefits: Payments to your spouse, children or other dependents if you die from a job injury or illness. The amount of payment is based on the number of dependents. The benefit is paid every two weeks at a rate of at least **$224 per week**. In addition, workers' compensation provides a burial allowance.

OTHER BENEFITS

You may file a claim with the Employment Development Department (EDD) to get state disability benefits when workers' compensation benefits are delayed, denied, or have ended. There are time restrictions so for more information contact the local office of EDD or go to their web site www.edd.ca.gov.

WORKERS' COMPENSATION FRAUD IS A CRIME

Any person who makes or causes to be made any knowingly false statement in order to obtain or deny workers' compensation benefits or payments is guilty of a felony. If convicted, the person will have to pay fines up to $150,000 and/or serve up to five years in jail.

WHAT SHOULD I DO IF I HAVE AN INJURY?

Report your injury to your employer: Tell your supervisor right away no matter how slight the injury may be. Don't delay – there are time limits. You could lose your right to benefits if your employer does not learn of your injury within 30 days. If your injury or illness is one that develops over time, report it as soon as you learn it was caused by your job. If you cannot report to the employer or don't hear from the claims administrator after you have reported your injury, contact the claims administrator yourself.

You may be able to find the name of your employer's workers' compensation insurer at www.caworkcompcoverage.com. If no coverage exists or coverage has expired, contact the Division of Labor Standards Enforcement at www.dir.ca.gov/DLSE as all employees must be covered by law.

Get emergency treatment if needed: If it's a medical emergency requiring an ambulance, fire department, or police; call 911. If an ambulance is not required go to an emergency room right away. For non-emergency medical care, contact your employer. When you arrive at the facility tell the medical provider who treats you that your injury is job-related. Your employer may tell you where to go for treatment.

Fill out DWC 1 claim form and give it to your employer: Your employer must give you a **DWC 1 claim form** within **one working day** after learning about your injury or illness. Complete the employee portion, sign and give it back to your employer. Your employer will then file your claim with the claims administrator. Your employer must authorize treatment within **one working day** of receiving the **DWC 1 claim form.** If the injury is from repeated exposures, you have **one year** from when you realized your injury was job related to file a claim.

In either case, you may receive up to **$10,000** in employer-paid medical care until your claim is either accepted or denied. The claims administrator has **up to 90 days** to decide whether to accept or deny your claim. Otherwise, your case is presumed payable. Your employer or the claims administrator will send you "benefit notices" that will advise you of the status of your claim.

MORE ABOUT MEDICAL CARE

What is a Primary Treating Physician (PTP)? This is the doctor with overall responsibility for treating your injury or illness. He or she may be:

- The doctor you name in writing before you get hurt on the job
- A doctor from the medical provider network (MPN)
- The doctor chosen by your employer during the first 30 days of injury if your employer does not have an MPN
- The doctor you chose after the first 30 days if your employer does not have a MPN

What is a Medical Provider Network (MPN)? A MPN is a select group of health care providers who treat injured workers. Check with your employer to see if they are using a MPN. If you have not named a doctor before you get hurt and your employer is using a MPN, you will see a MPN doctor. After your first visit, you are free to choose another doctor from the MPN list.

What is Predesignation? Predesignation is when you name your regular doctor to treat you if you get hurt on the job. The doctor must be a medical doctor (M.D.), doctor of osteopathic medicine (D.O.) or a medical group with an

M.D. or D.O. You must name your doctor in writing before you get hurt or become ill.

You may predesignate a doctor if you have health care coverage for non-work injuries and illnesses. The doctor must have:

- Treated you
- Maintained your medical history and records before your injury and
- Agreed to treat you for a work-related injury or illness before you get hurt or become ill

You may use the "predesignation of personal physician" form included with this pamphlet. After you fill in the form, be sure to give it to your employer. If your employer does not have an approved MPN, you may name your chiropractor or acupuncturist to treat you for work related injuries. The notice of personal chiropractor or acupuncturist must be in writing before you get hurt. You may use the form included in this pamphlet. After you fill in the form, be sure to give it to your employer.

With some exceptions, state law does not allow a chiropractor to continue as your treating physician after **24 visits**. Once you have received 24 chiropractic visits, if you still require medical treatment, you will have to select a new physician who is not a chiropractor. The term "chiropractic visit" means any chiropractic office visit, regardless of whether the services performed involve chiropractic manipulation or are limited to evaluation and management.

Exceptions to 24 visits include postsurgical physical medicine visits prescribed by the surgeon, or physician designated by the surgeon, under the postsurgical component of the Division of Workers' Compensation's Medical Treatment Utilization Schedule, or if your employer has authorized additional visits in writing.

WHAT IF THERE IS A PROBLEM?

If you have a concern, speak up. Talk to your employer or the claims administrator handling your claim and try to solve the problem. If this doesn't work, get help by trying the following:

Contact the Division of Workers' Compensation (DWC) Information and Assistance (I&A) Unit. All 24 DWC offices throughout the state provide information and assistance on rights, benefits and obligations under California's workers' compensation laws. I&A officers help resolve disputes without formal proceedings. Their goal is to get you full and timely benefits. Their services are free. To contact the nearest I&A Unit, go to https:// www.dir.ca.gov/dwc/ianda.html or call **1-800-736-7401**.

You have the right to consult with an attorney: Most attorneys offer one free consultation. If you decide to hire an attorney, his or her fees may be taken out of some of your benefits. For names of workers' compensation attorneys, call the State Bar of California at **1-415-538-2120** or go visit their website at www.californiaspecialist.org. You may also get a list of attorneys from your local I&A Unit by calling **1-800-736-7401**.

WARNING

Your employer may not pay workers' compensation benefits if you get hurt in a voluntary off-duty recreational, social or athletic activity that is not part of your work-related duties.

You may also have other rights under the Americans with Disabilities Act (ADA) or the California Fair Employment and Housing Act (FEHA). For additional information, contact California Civil Rights Department (CRD) at 1-800-884-1684 or the Equal Employment Opportunity Commission (EEOC) at 1-800-669-4000.

The information contained in this pamphlet conforms to the informational requirements found in Labor Code sections 3551 and 3553 and California Code of Regulation, Title 8, sections 9880 and 9883. This document is approved by the Division of Workers' Compensation administrative director.

Please visit theDivision of Workers' Compensation Web site at: www.dwc.ca.gov or call 1-800-736-7401 Department of Industrial Relations 1515 Clay Street, 17th Floor Oakland, CA 94612

Revised 2/01/2024 and effective for dates of injuries on or after 1/1/13.

WHEN A WORK INJURY OCCURS:

- Quickly seek first aid
- Call 9-1-1 for help immediately in emergency medical care is needed
- Immediately report injuries to your supervisor

Workers' compensation insurance company or if employer is self-insured, person responsible for handling the claim is:
Athens Administration
Address: PO Box 696
Concord, CA 94522-0696
Phone: 925-482-3535

MPN Website:
https://www.medexadvantage.com/athens/

MPN Effective Date: 7/1/2019

MPN ID: 2437

For non-emergency medical care, contact your employer, the WC claims administrator, or go to one of these facilities:
Sutter Gould Medical

For help location an MPN physician, call or email your MPN access assistant at:
1-888-509-1474
MAA@medexhco.com

For MPN Questions, call:
1-866-482-3535
Or email lfarlander@athensadmin.com

Information & Assistance Office:
2550 Mariposa Mall, Room 5005
Fresno, CA 93721-2219
1-559-445-5355

PREDESIGNATION OF PERSONAL PHYSICIAN

In the event you sustain an injury or illness related to your employment, you may be treated for such injury or illness by your personal medical doctor (M.D.), doctor of osteopathic medicine (D.O.) or medical group if:

- on the date of your work injury you have health care coverage for injuries or illnesses that are not work related;
- the doctor is your regular physician, who shall be either a physician who has limited his or her practice of medicine to general practice or who is a board-certified or board-eligible internist, pediatrician, obstetrician-gynecologist, or family practitioner, and has previously directed your medical treatment, and retains your medical records;
- your "personal physician" may be a medical group if it is a single corporation or partnership composed of licensed doctors of medicine or osteopathy, which operates an integrated multispecialty medical group providing comprehensive medical services predominantly for nonoccupational illnesses and injuries;
- prior to the injury your doctor agrees to treat you for work injuries or illnesses;
- prior to the injury you provided your employer the following in writing: (1) notice that you want your personal doctor to treat you for a work-related injury or illness, and (2) your personal doctor's name and business address.

You may use this form to notify your employer if you wish to have your personal medical doctor or a doctor of osteopathic medicine treat you for a work-related injury or illness and the above requirements are met.

NOTICE OF PREDESIGNATION OF PERSONAL PHYSICIAN: (Employee: Complete this section)

To (name of Employer): _____

If I have a work-related injury or illness, I choose to be treated by: (name of doctor, M.D., D.O., or medical group) (street address, city, state, ZIP) _____

Employee Name (please print): _____

Employee address: _____

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

Employee's Signature: _____ Date: _____

PHYSICIAN: I AGREE TO THIS PREDESIGNATION:

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

Signature: _____ Date: _____

The physician is not required to sign this form, however, if the physician or designated employee of the physician or medical group does not sign, other documentation of the physician's agreement to be predesignated will be required pursuant to Title 8, California Code of Regulations, section 9780.1(a)(3).

NOTICE OF PERSONAL CHIROPRACTOR OR PERSONAL ACUPUNCTURIST

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

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

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

YOUR CHIROPRACTOR OR ACUPUNCTURIST'S INFORMATION:

Name of chiropractor or acupuncturist: _____

Street address, city, state, zip code: _____

Telephone number: _____

Employee Name (please print): _____

Employee address: _____

Employee's Signature: _____ Date: _____

Información Acerca de Compensación del Trabajador

Yosemite Community College District (YCCD)

ATHENS People, Powered.

PO Box 696
Concord, CA 94522-0696
925-482-3535

En vigor para las fechas de lesiones a partir del 1 de enero de 2013 –
Revisado el 1 de febrero de 2024

Este aviso, o uno similar que haya sido aprobado por el Director Administrativo, deben entregarse a todos los empleados recién contratados en el estado de California. Los empleadores y administradores de reclamos pueden utilizar el contenido de este documento y colocar en él sus logotipos e información adicional. El contenido de este folleto se aplica a todos los accidentes de trabajo ocurridos a partir del 1 de enero de 2013.

¿QUÉ ES LA COMPENSACIÓN DE TRABAJADORES?

Si se lesiona en el trabajo, su empleador está obligado por ley a pagarle beneficios de compensación de trabajadores. Podría resultar herido por:

Un suceso en el trabajo. Ejemplos: hacerse daño en la espalda en una caída, quemarse con un producto químico que le salpique la piel o lesionarse en un accidente de automóvil mientras hace repartos.

OR

Exposiciones repetidas en el trabajo. Ejemplos: lastimarse la mano, la espalda u otra parte del cuerpo por hacer el mismo movimiento repetido o perder la audición por ruidos fuertes y constantes.

OR

Delitos en el lugar de trabajo. Ejemplos: resulta herido en un atraco a una tienda, es agredido físicamente por un cliente descontento.

LA DISCRIMINACIÓN ES ILEGAL

Según la sección 132a del Código Laboral, es ilegal que su empleador lo castigue o despida porque usted:

- Presenta un reclamo de compensación de trabajadores
- Tiene intención de presentar un reclamo de compensación de trabajadores
- Concilia un reclamo de compensación de trabajadores
- Testifica o tiene intención de testificar por otro trabajador lesionado

Si se determina que su empleador lo ha discriminado, puede ordenársele que lo reincorpore a su puesto de trabajo; su empleador también puede verse obligado a pagar los salarios perdidos, el aumento de los beneficios de compensación por accidentes laborales y los costos y gastos establecidos por la legislación estatal.

¿CUÁLES SON LOS BENEFICIOS?

Atención médica: pagada por su empleador para ayudarlo a recuperarse de una lesión o enfermedad causada por el trabajo. Las visitas al médico, los servicios hospitalarios, la fisioterapia, las pruebas de laboratorio y las radiografías son algunos de los servicios médicos que pueden prestarse; estos servicios deben ser necesarios para tratar su lesión. Existen límites para algunos servicios, como la fisioterapia, la terapia ocupacional y la quiropráctica.

Beneficios por discapacidad temporal (Temporary Disability, TD): pagos si pierde salario porque su lesión le impide realizar su trabajo habitual mientras se recupera. El monto que puede recibir es de hasta dos tercios de su salario. Existen límites mínimos y máximos de pago establecidos por la legislación estatal; se le pagará cada dos semanas si es elegible. Para la mayoría de las lesiones, los pagos no pueden superar las 104 semanas en un plazo de cinco años a partir de la fecha de la lesión. La discapacidad temporal (TD) finaliza cuando vuelve al trabajo, o cuando el médico le da el alta para trabajar o dice que su lesión ha mejorado todo lo que va a mejorar.

Beneficios por discapacidad permanente (Permanent Disability, PD): pagos si no se recupera del todo. se le pagará cada dos semanas si es elegible. Existen tasas de pago semanales mínimos y máximos establecidos por la legislación estatal; el monto del pago se basa en:

- Los informes médicos de su doctor.
- Su edad.
- Su profesión.

Beneficio suplementario por el desplazamiento de trabajo (Supplemental Job Displacement Benefits, SJDB): se trata de un vale de hasta $6,000 que puede utilizar para volver a capacitarse o mejorar sus conocimientos en una escuela aprobada, para libros, herramientas, licencias o tarifas de certificación, u otros recursos que lo ayuden a encontrar un nuevo empleo; Es elegible a este vale si:

- Tiene una discapacidad permanente.
- Su empleador no le ofrece un trabajo regular, modificado o alternativo, **dentro de los 60 días** posteriores a que el administrador de reclamos reciba un informe médico que indique que usted ha logrado una recuperación médica máxima.

Programa Suplementario de Regreso al Trabajo (Return-to-Work Supplemental Program, RTWSP): para las fechas de lesión después del 1 de enero de 2013, usted puede calificar para dinero adicional del programa de la División de Compensación de Trabajadores conocido como el Programa Suplementario de Regreso al Trabajo (RTWSP) si usted recibió el vale de los Beneficios Suplementarios por el Desplazamiento de Trabajo (SJDB). Si tiene alguna pregunta o cree que reúne los requisitos, póngase en contacto con la Unidad de Información y Asistencia llamando al 1-800-736-7401 o visite el sitio web: https://www.dir.ca.gov/RTWSP/RTWSP.html

Beneficios por muerte: pagos a su cónyuge, hijos u otras personas a su cargo si fallece a causa de una lesión o enfermedad laboral. El monto del pago depende del número de personas a cargo. El beneficio se paga cada dos semanas a una tasa de, como mínimo, **$224 semanales;** además, la compensación de trabajadores prevé un subsidio de sepelio.

OTROS BENEFICIOS

Puede presentar un reclamo ante el Departamento de Desarrollo del Empleo (Employment Development Department, EDD) para obtener beneficios estatales por discapacidad cuando los beneficios de compensación de trabajadores se retrasen, denieguen o hayan finalizado. Hay restricciones de tiempo, así que para más información póngase en contacto con la oficina local del EDD o visite su sitio web: www.edd.ca.gov.

EL FRAUDE EN LA COMPENSACIÓN DE TRABAJADORES ES DELITO

Toda persona que realice o haga realizar cualquier declaración deliberadamente falsa con el fin de obtener o denegar beneficios o pagos de compensación de trabajadores es culpable de un delito grave; si es declarada culpable, la persona tendrá que pagar multas de hasta $150,000 o cumplir hasta cinco años de cárcel.

¿QUÉ DEBO HACER SI TENGO UNA LESIÓN?

Informe la lesión a su empleador: Informe inmediatamente a su supervisor, por leve que sea la lesión; no se demore, hay plazos. Puede perder el derecho a los beneficios si su empleador no se entera de su lesión en un plazo de 30 días. Si su lesión o enfermedad se desarrolla con el tiempo, notifíquelo en cuanto sepa que ha sido causada por su trabajo. Si no puede informar al empleador o no tiene noticias del administrador de reclamos después de haber informado sobre su lesión, comuníquese usted mismo con el administrador de reclamos.

Puede encontrar el nombre de la compañía de seguros de compensación de trabajadores de su empleador en www.caworkcompcoverage.com. Si no existe cobertura o ésta ha expirado, póngase en contacto con la División de Cumplimiento de las Normas Laborales en www.dir.ca.gov/DLSE ya que todos los empleados deben tener cobertura por ley.

Reciba tratamiento de urgencia si es necesario: Si se trata de una urgencia médica, acuda de inmediato a urgencias. Informe al proveedor médico que lo atiende de que su lesión está relacionada con el trabajo. Su empleador puede indicarle dónde acudir para recibir tratamiento.

Rellene el formulario de reclamos DWC 1 y entréguelo a su empleador: Su empleador debe entregarle un Formulario de reclamos DWC 1 en el plazo de un día hábil tras conocer su lesión o enfermedad. Rellene la parte correspondiente al empleado, fírmela y devuélvala a su empleador. A continuación, su empleador presentará el reclamo al administrador de reclamos. Su empleador debe autorizar el tratamiento en el plazo de un día hábil a partir de la recepción del **formulario de reclamos DWC 1**. Si la lesión se debe a exposiciones repetidas, dispone **de un año** desde el momento en que se dio cuenta de que su lesión estaba relacionada con el trabajo para presentar un reclamo.

En ambos casos, puede recibir hasta $10,000 en concepto de atención médica pagada por el empleador hasta que se acepte o deniegue su reclamo. El administrador de reclamos tiene hasta 90 días para decidir si acepta o rechaza su reclamo; de lo contrario, su caso se presume pagadero. Su empleador o el administrador de reclamos le enviarán "avisos de beneficios" que le informarán de la situación de su reclamo.

MÁS SOBRE LA ATENCIÓN MÉDICA

¿Qué es un médico tratante principal (Primary Treating Physician, PTP)? Es el médico responsable del tratamiento de su lesión o enfermedad. Él o ella pueden ser:

- El médico que nombra por escrito antes de lesionarse en el trabajo.
- Un médico de la red de proveedores médicos (Medical Provider Network, MPN).
- El médico elegido por su empleador durante los 30 primeros días de la lesión si su empleador no dispone de una MPN.
- El médico que haya elegido después de los primeros 30 días si su empleador no dispone de una MPN.

¿Qué es una red de proveedores médicos (MPN)? Una MPN es un grupo selecto de proveedores de atención médica que tratan a trabajadores lesionados. Consulte a su empresa si utiliza una MPN. Si no ha nombrado a un médico antes de lesionarse y su empleador utiliza una MPN, acudirá a un médico de la MPN; después de su primera visita, es libre de elegir otro médico de la lista de la MPN.

¿Qué es la designación previa? La designación previa es cuando nombra a su médico habitual para que lo trate si se lesiona en el trabajo. El médico debe ser doctor en medicina (Medical Doctor, MD), doctor en medicina osteopática (Doctor of Osteopathic Medicine, DO) o un grupo médico con un MD o DO. Debe nombrar a su médico por escrito antes de lesionarse o enfermarse; puede designar previamente a un médico si tiene cobertura de atención médica para lesiones y enfermedades no laborales. El médico debe:

- Haberlo tratado.
- Haber mantenido su historial y expedientes médicos antes de la lesión.
- Haber acordado tratarlo por una lesión o enfermedad relacionada con el trabajo antes de que se lesionara o enfermara.

Puede utilizar el formulario de "designación previa de médico personal" incluido en este folleto. Después de rellenar el formulario, no olvide entregárselo a su empleador; si su empleador no tiene una MPN aprobada, puede nombrar a su quiropráctico o acupunturista para que le trate las lesiones relacionadas con el trabajo. El aviso del quiropráctico o acupunturista personal debe hacerse por escrito antes de que se lesione. Puede utilizar el formulario incluido en este folleto; Después de rellenar el formulario, no olvide entregárselo a su empleador;

Con algunas excepciones, la ley estatal no permite que un quiropráctico siga siendo su médico tratante después de 24 consultas. Una vez que haya recibido 24 consultas quiroprácticas, si sigue necesitando tratamiento médico, tendrá que elegir un nuevo médico que no sea quiropráctico. Por "consulta quiropráctica" se entiende cualquier visita a un consultorio quiropráctico, independientemente de que los servicios prestados impliquen manipulación quiropráctica o se limiten a evaluación y gestión.

Las excepciones a las 24 consultas incluyen las consultas de medicina física posquirúrgicas prescritas por el cirujano, o el médico designado por el cirujano, en virtud del componente posquirúrgico del Programa de Utilización de Tratamientos Médicos de la División de Compensación por Accidentes Laborales, o si su empleador ha autorizado consultas adicionales por escrito.

¿Y SI HAY ALGÚN PROBLEMA?

Si tiene alguna preocupación, dígalo. Hable con su empleador o con el administrador de reclamos que tramita su reclamo e intente resolver el problema; si esto no funciona, pida ayuda probando lo siguiente:

Póngase en contacto con la Unidad de Información y Asistencia (Information and Assistance, I&A) de la División de Compensación de Trabajadores: Division of Workers' Compensation, DWC). Las 24 oficinas de la DWC repartidas por todo el estado ofrecen información y asistencia sobre derechos, beneficios y obligaciones en virtud de las leyes de compensación por accidentes laborales de California. Los funcionarios de la I&A ayudan a resolver conflictos sin procedimientos formales. Su meta es conseguirle beneficios completos y a tiempo; sus servicios son gratuitos. Para ponerse en contacto con la Unidad de I&A más cercana, visite www.dir.ca.gov/dwc/ianda.html o llame al 1-800-736-7401.

Consulte con un abogado:
La mayoría de los abogados ofrecen una consulta gratuita. Si decide contratar a un abogado, sus honorarios pueden deducirse de algunos de sus beneficios. Para obtener los nombres de los abogados de compensación por accidentes laborales, llame al Colegio de Abogados del Estado de California al 1-415-538-2120 o visite su sitio web en www.californiaspecialist.org. También puede obtener una lista de abogados en la Unidad de I&A local llamando al 1-800-736-7401.

ADVERTENCIA

Es posible que su empleador no le pague la compensación de trabajadores si se lesiona en una actividad recreativa, social o deportiva voluntaria fuera del trabajo que no forme parte de sus obligaciones laborales.

También puede tener otros derechos en virtud de la Ley federal de Americanos con Discapacidades (Americans with Disabilities Act, ADA) o la Ley de Justicia en el Empleo y la Vivienda (Fair Employment and Housing Act, FEHA) de California. Para obtener más información, póngase en contacto con el Departamento de Derechos Civiles (Civil Rights Department, CRD) de California, llamando al 1-800-884-1684, o con la Comisión para la Igualdad de Oportunidades en el Empleo (Equal Employment Opportunity Commission, EEOC), llamando al 1-800-669-4000.

La información contenida en este folleto se ajusta a los requisitos informativos que figuran en las secciones 3551 y 3553 del Código Laboral y en las secciones 9880 y 9883 del título 8 del Código de Reglamentos de California. Este documento ha sido aprobado por el director administrativo de la División de Compensación de Trabajadores.

Visite el sitio web de la División de Compensación de Trabajadores
www.dwc.ca.gov o llame al 1-800-736-7401
Departamento de Relaciones Industriales
1515 Clay Street, 17th Floor
Oakland, CA 94612

En vigor para las fechas de lesiones a partir del 1 de enero de 2013 – Revisado el 1 de febrero de 2024

CUANDO OCURRE UNA LESIÓN EN EL TRABAJO:

- Busque rápidamente primeros auxilios.
- Llame al 9-1-1 para solicitar ayuda inmediata, si es una emergencia, se requiere atención médica.
- Reporte inmediatamente cualquier incidente, lesion ocurrido a su supervisor

Compañía de seguros de compensación para trabajadoreso si el empleador está autoasegurado, la persona El responsable de la gestión de la reclamación es:
Athens Administration
Dirección: PO Box 696
Concord, CA
Teléfono: 925-482-3535

MPN Website:
https://www.medexadvantage.com/athens/

MPN sera efectiva a partir desde el: 7/1/2019

El Numero de identificacion de la MPN: 2437

Para atención médica que no sea de emergencia, comuníquese con su empleador, el administrador de reclamos de WC, o diríjase a una de estas instalaciones:
Sutter Gould Medical (Médico Sutter Gould)

Si necesitas ayuda en locazilar un medico dentro de la MPN, llame al asistente de acceso de tu MPN:
1-888-509-1474
MAA@medexhco.com

Para cualquier pregunta acerca del la MPN, llama al:
1-866-482-3535
Or email lfarlander@athensadmin.com

Officina de Información y Asistencia:
2550 Mariposa Mall, Room 5005
Fresno, CA 93721-2219
1-559-445-5355

DESIGNACIÓN PREVIA DEL MÉDICO PERSONAL

En caso de que sufra una lesión o enfermedad relacionada con su empleo, podrá ser tratado de dicha lesión o enfermedad por su doctor en medicina (MD) personal, médico osteópata (DO) o grupo médico si:

- en la fecha de su accidente laboral tiene cobertura de atención médica por lesiones o enfermedades no relacionadas con el trabajo;
- el médico es su médico habitual, que será un médico que haya limitado su ejercicio de la medicina a la práctica general o que sea internista, pediatra, ginecólogo-obstetra o médico de familia colegiado o habilitado, y que haya dirigido previamente su tratamiento médico y conserve su historial médico;
- su "médico personal" puede ser un grupo médico si se trata de una sola corporación o sociedad compuesta por médicos licenciados en medicina u osteopatía, que gestiona un grupo médico multiespecialidad integrado que presta servicios médicos integrales predominantemente para enfermedades y lesiones no profesionales;
- antes de la lesión, su médico acepta tratarlo por lesiones o enfermedades laborales;
- antes de producirse la lesión, facilitó por escrito a su empleador la siguiente información: (1) aviso de que desea que su médico personal lo atienda por una lesión o enfermedad relacionada con el trabajo y (2) el nombre y la dirección profesional de su médico personal.

Puede utilizar este formulario para avisar a su empleador si desea que su médico personal o un médico osteópata lo atienda por una lesión o enfermedad relacionada con el trabajo y se cumplen los requisitos anteriores.

AVISO DE DESIGNACIÓN PREVIA DEL MÉDICO PERSONAL: (Empleado: Complete esta sección.)

Para (nombre del empleador): _____

Si tengo una lesión o enfermedad relacionada con el trabajo, elijo ser tratado por: (nombre del médico MD, DO o grupo médico) (dirección, ciudad, estado, código postal, número de teléfono) _____

Nombre del empleado (en letra de imprenta): _____

Dirección del empleado: _____

Nombre de la compañía de seguros, plan o fondo que brinda cobertura de atención médica para lesiones o enfermedades no profesionales: _____

Firma del empleado: _____ Fecha: _____

MÉDICO: ESTOY DE ACUERDO CON ESTA DESIGNACIÓN PREVIA:

(Médico o empleado designado del médico o grupo médico)

Firma: _____ Fecha: _____

El médico no está obligado a firmar este formulario, sin embargo, si el médico o empleado designado del médico o grupo médico no firma, se requerirá otra documentación del acuerdo del médico para ser predesignado de conformidad con el título 8 del Código de Reglamentos de California, sección 9780.1(a) (3).

AVISO DE QUIROPRÁCTICO PERSONAL O ACUPUNTURISTA PERSONAL

Si su empleador o la aseguradora de su empleador no disponen de una red de proveedores médicos, es posible que pueda cambiar su médico tratante por su quiropráctico o acupunturista personal tras una lesión o enfermedad laboral. Para ser elegible para este cambio, debe comunicar por escrito a su empleador el nombre y la dirección profesional de un quiropráctico o acupunturista personal antes de la lesión o enfermedad. Por lo general, su administrador de reclamos tiene derecho a seleccionar a su médico tratante dentro de los primeros 30 días después de que su empleador tenga conocimiento de su lesión o enfermedad; después de que el administrador de reclamos haya iniciado su tratamiento con otro médico durante este periodo, podrá, previa solicitud, transferir su tratamiento a su quiropráctico o acupunturista personal.

NOTA: si su fecha de lesión es el 1.° de enero de 2004 o posterior, un quiropráctico no puede ser su médico tratante después de que haya recibido 24 consultas quiroprácticas, a menos que su empleador haya autorizado por escrito consultas adicionales. Por "consulta quiropráctica" se entiende cualquier visita a un consultorio quiropráctico, independientemente de que los servicios prestados impliquen manipulación quiropráctica o se limiten a evaluación y gestión. Una vez que haya recibido 24 consultas quiroprácticas, si sigue necesitando tratamiento médico, tendrá que elegir un nuevo médico que no sea quiropráctico. Esta prohibición no se aplicará a las consultas de medicina física posquirúrgica prescritas por el cirujano, o el médico designado por el cirujano, en virtud del componente posquirúrgico del Programa de Utilización de Tratamientos Médicos de la División de Compensación de trabajadores.

Puede utilizar este formulario para notificar a su empleador su quiropráctico o acupunturista personal.

INFORMACIÓN SOBRE SU QUIROPRÁCTICO O ACUPUNTURISTA::

Nombre del quiropráctico o acupunturista: _____

Dirección, ciudad, estado, código postal: _____

Número de teléfono: _____

Nombre del empleado (en letra de imprenta): _____

Dirección del empleado: _____

Firma del empleado: _____ Fecha: _____

Título 8 del Código de Reglamentos de California, sección 9783.1.
(Formulario opcional DWC 9783.1 Fecha de entrada en vigor: 1.° de julio de 2014)