COLOR KEY

Employee | **Admin/Manager** | **Human Resources**

MT. SAN ANTONIO COLLEGE
Temporary Hiring Checklist

Name: _____ Banner ID: ___ Leave blank if unknown

Please complete and attach this checklist to the Temporary Employment Form and new hire documents to ensure all required paperwork is complete prior to submission to Human Resources. ***INCOMPLETE PAPERWORK MAY CAUSE CONSIDERABLE DELAY IN EMPLOYEE RECEIVING PAY WARRANTS PROMPTLY.***

Employee Received	Returned To HR	**Required Paperwork**:
☐	☐	Temporary Employment Form
☐	☐	Online Application Number Confirmation Received
☐	☐	Withholding Forms – Federal & State
☐	☐	Employment Eligibility Verification - I-9 Form *(Instructions and list of acceptable documents on reverse side of I-9)*
☐	☐	Social Security card *(for IRS purposes)*
☐	☐	Oath of Allegiance
☐	☐	Warrant Designation
☐	☐	Confidentiality and Appropriate Work Attire Agreement Form
☐	☐	Hepatitis B Vaccination Program and Acknowledgement Form
☐	☐	Asbestos Notification and Acknowledgement Form
☐	☐	FMLA Information and Acknowledgement Form
☐	☐	Non-Discrimination Statement and Acknowledgement Form
☐	☐	District Policy on Drug Free Environment and Acknowledgement Form
☐	☐	Reasonable Accommodation Information and Acknowledgement Form
☐	☐	Sexual Harassment Brochure and Acknowledgement Form
☐	☐	Use of Technology and Information Resources and Employee Acceptable Use Agreement *(AP 3720)* and Acknowledgement Form
☐	☐	Notice of Exclusion from CalPERS Membership
☐	☐	CalPERS Reciprocal Self- Certification Form
☐	☐	Worker's Compensation Pre-Designation Personal Physician Form
		Optional Paperwork:
☐	☐	Direct Deposit Authorization Form ❒ *(attached voided check)*
		Informational Paperwork (For employee records):
☐		Emergency Response Quick Reference Guide
☐		Disaster Service Workers Brochure
☐		Worker's Compensation Information
☐		FMLA, PDL, and CFRA Information
☐		Notice of Social Security Alternative Plan – National Benefit Services (NBS)

HR Use Only:

☐ Notice to Employee (Labor Code 2810.5) including Wage Information/Worker's Compensation/Paid Sick Leave/Affordable Care Act generated and sent to employee.

Date: _____ HRT: _____

New Hire: ☐ Returning: ☐	**MT. SAN ANTONIO COLLEGE** **Temporary Employment Form**	Banner ID A#:

Last Name:	First Name:	MI:	Preferred First Name (Optional):
Address:	City:	State:	Zip Code:
Gender: ☐ Male ☐ Female ☐ Other	DOB:	Phone #1: Phone #2:	Email:

I am a CalPERS member: Yes ☐ No ☐ If yes, are you a retired CalPERS member?: Yes ☐ No ☐

EMERGENCY CONTACT INFORMATION

Name: _____ Relationship: _____ Telephone #: _____

I have verified my mailing address above and understand this is where my paycheck & employment forms will be mailed.

EMPLOYEE SIGNATURE: _____ Date: _____

The sections below are to be completed by Department Hiring Authority

Employee Classification (Per Ed Code Section 88003)

Please choose the type of classification of employee you are requesting to hire.

Select one position & Level

Short-Term

- ☐ Administrative Support
- ☐ Athletic Support
- ☐ Campus Safety Support
- ☐ Campus Services Support
- ☐ Fiscal Support
- ☐ Instructional Support
- ☐ Student Services Support
- ☐ Technical Support
- ☐ Facilities Support - Custodial
- ☐ Facilities Support - Grounds
- ☐ Facilities Support - Maintenance

Level: ☐ I ☐ II ☐ III ☐ IV ☐ V

Professional Expert

- ☐ Art Model Expert
- ☐ Project Expert
- ☐ Tutor Expert
- ☐ Project Manager
- ☐ Technical Expert
- ☐ Not-for-Credit-Instructor
- ☐ Licensed Professionals
- ☐ Interpreter
- ☐ Real Time Captioner
- ☐ Project Administrator
- ☐ Special Assignment Expert/ Administrator

Level: ☐ I ☐ II ☐ III ☐ IV ☐ V

Student Assistant

Level: ☐ I ☐ II ☐ III ☐ IV ☐ V

# of Units: ____ Session: _____

Substitute

Classified Title: _____

Range: _____

☐ Pool (Custodian and Grounds)

☐ Vacancy For whom: _____

☐ Absence For whom: _____

Briefly describe work being performed and/or scope of project:

REQUIRED

Is this employee currently working in any other department?: Yes ☐ No ☐

If yes, Department: _____ Manager: _____

Is this the work of an Instructional Aide? ☐ Yes ☐ No

If yes, are the duties performed under the general direction of an instructor? ☐ Yes ☐ No

Department Name:	Online Application Confirmation #:
Department Location:	

Hourly Rate:	Start Date:	End Date:	Department Contact/Extension:

Position #	Fund	Organization	Account	Program	Check box if adding a new account string ONLY, include effective dates & manager initial
					☐
					☐
					☐
					☐
					☐

Account adds must include new dates/manager initial with date and highlighted account string

Print & sign legibly

SIGNATURES AND APPROVALS

Manager Print (Required):	Manager Signature (Required):	Date (Required):
VP Signature/Date:	HR Initial/Date:	Board Approval Date:

Students do not need VP sig

Whiteout is not allowed on federal forms

Form **W-4**

Department of the Treasury
Internal Revenue Service

Employee's Withholding Certificate

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

OMB No. 1545-0074

2022

Step 1: Enter Personal Information

(a) First name and middle initial | Last name | **(b) Social security number**

Address

Contact Payroll if you have questions on completing this form

City or town, state, and ZIP code

▶ **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*.

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

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

Step 2: Multiple Jobs or Spouse Works

Complete this step if you (1) hold more than one job at a time, or (2) are married filing jointly and your spouse also works. The correct amount of withholding depends on income earned from all of these jobs.

Do **only one** of the following.

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

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

(c) If there are only two jobs total, you may check this box. Do the same on Form W-4 for the other job. This option is accurate for jobs with similar pay; otherwise, more tax than necessary may be withheld . . ▶ ☐

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

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

Step 3: Claim Dependents

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

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

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

Add the amounts above and enter the total here . . . . . **3** $

Step 4 (optional): Other Adjustments

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

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

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

Step 5: Sign Here

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

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

Employers Only

Employer's name and address	First date of employment	Employer identification number (EIN)
Mt. San Antonio College 1100 N. Grand Avenue Walnut, CA 91789		

Whiteout is not allowed on federal forms

Employment Development Department
State of California

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

Contact Payroll if you have questions on completing this form

EMPLOYEE'S WITHHOLDING ALLOWANCE CERTIFICATE

Type or Print Your Full Name	Your Social Security Number
Home Address (Number and Street or Rural Route)	Filing Status Withholding Allowances ☐ SINGLE or MARRIED (with two or more incomes) ☐ MARRIED (one income) ☐ HEAD OF HOUSEHOLD
City, State, and ZIP Code	

1. Number of allowances for Regular Withholding Allowances, Worksheet A _____
   Number of allowances from the Estimated Deductions, Worksheet B _____
   Total Number of Allowances (A + B) when using the California Withholding Schedules for 2017 _____
   OR
2. Additional amount of state income tax to be withheld each pay period (if employer agrees), Worksheet C _____
   OR
3. I certify under penalty of perjury that I am not subject to California withholding. I meet the conditions set forth under the Service Member Civil Relief Act, as amended by the Military Spouses Residency Relief Act. (Check box here) ☐

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

Signature _____ Date _____

Employer's Name and Address	California Employer Account Number
Mt. San Antonio College 1100 N. Grand Avenue Walnut, Ca 91789	

cut here

Give the top portion of this page to your employer and keep the remainder for your records.

YOUR CALIFORNIA PERSONAL INCOME **TAX MAY BE UNDERWITHHELD** IF YOU DO NOT FILE THIS DE 4 FORM.

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

PURPOSE: This certificate, DE 4, is for **California Personal Income Tax (PIT) withholding** purposes only. The DE 4 is used to compute the amount of taxes to be withheld from your wages, by your employer, to accurately reflect your state tax withholding obligation.

You should complete this form if either:

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

(2) You claim additional allowances for estimated deductions.

THIS FORM WILL NOT CHANGE YOUR FEDERAL WITHHOLDING ALLOWANCES.

The federal Form W-4 is applicable for California withholding purposes if you wish to claim the same marital status, number of regular allowances, and/or the same additional dollar amount to be withheld for state and federal purposes. However, federal tax brackets and withholding methods do not reflect state PIT withholding tables. **If you rely on the number of withholding allowances you claim on your Form W-4 withholding allowance certificate for your state income tax withholding, you may be significantly underwithheld.** This is particularly true if your household income is derived from more than one source.

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

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

Employment Eligibility Verification

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

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

Whiteout is not allowed on federal forms

▶**START HERE:** **Read instructions carefully before completing this form. The instructions must be available, either in paper or electronically, during completion of this form. Employers are liable for errors in the completion of this form.**

ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers **CANNOT** specify which document(s) an employee may present to establish employment authorization and identity. The refusal to hire or continue to employ an individual because the documentation presented has a future expiration date may also constitute illegal discrimination.

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

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

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

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

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

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

☐ 1. A citizen of the United States

☐ 2. A noncitizen national of the United States *(See instructions)*

☐ 3. A lawful permanent resident (Alien Registration Number/USCIS Number): _____ If checked include #

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

Aliens authorized to work must provide only one of the following document numbers to complete Form I-9:
An Alien Registration Number/USCIS Number OR Form I-94 Admission Number OR Foreign Passport Number.

1. Alien Registration Number/USCIS Number: _____
OR
2. Form I-94 Admission Number: _____
OR
3. Foreign Passport Number: _____
Country of Issuance: _____

QR Code - Section 1
Do Not Write In This Space

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

Preparer and/or Translator Certification (check one):

☐ I did not use a preparer or translator. ☐ A preparer(s) and/or translator(s) assisted the employee in completing Section 1.
(Fields below must be completed and signed when preparers and/or translators assist an employee in completing Section 1.)

I attest, under penalty of perjury, that I have assisted in the completion of Section 1 of this form and that to the best of my knowledge the information is true and correct.

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

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

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

STOP *Employer Completes Next Page* STOP

Section 2. Employer or Authorized Representative Review and Verification

(Employers or their authorized representative must complete and sign Section 2 within 3 business days of the employee's first day of employment. You must physically examine one document from List A OR a combination of one document from List B and one document from List C as listed on the "Lists of Acceptable Documents.")

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

List A Identity and Employment Authorization	OR	List B Identity	AND	List C Employment Authorization
Document Title		Document Title		Document Title
Issuing Authority		Issuing Authority		Issuing Authority
Document Number		Document Number		Document Number
Expiration Date *(if any)(mm/dd/yyyy)*		Expiration Date *(if any)(mm/dd/yyyy)*		Expiration Date *(if any)(mm/dd/yyyy)*
Document Title				
Issuing Authority				
Document Number				
Expiration Date *(if any)(mm/dd/yyy*				
Document Title				
Issuing Authority				
Document Number				
Expiration Date *(if any)(mm/dd/yyyy)*				

List "A" may require multiple documents if applicable
OR
use one item to fulfill "List B" & "List C"
Do NOT over-document

A Social Security card must still be submitted for Payroll purposes regardless

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

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

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

Signature of Employer or Authorized Representative	Today's Date *(mm/dd/yyyy)*	Title of Employer or Authorized Representative
Must be completed by permanent employee		
Last Name of Employer or Authorized Representative	First Name of Employer or Authorized Representative	Employer's Business or Organization Name: Mt. San Antonioi College
Employer's Business or Organization Address (Street Number and Name): 1100 N. Grand Avenue	City or Town: Walnut, Ca	State: CA / ZIP Code: 91789

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

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

C. If the employee's previous grant of employment authorization has expired, provide the information for the document or receipt that establishes continuing employment authorization in the space provided below.

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

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

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

LISTS OF ACCEPTABLE DOCUMENTS

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

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

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

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

Refer to the instructions for more information about acceptable receipts.

MT. SAC
Mt. San Antonio College

HUMAN RESOURCES

OATH OF ALLEGIANCE

(Required by Government Code)

"I Print 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."*

_____
Signature of Employee

THE OATHS ABOVE SUBSCRIBED AND AFFIRMED TO BEFORE ME ON THIS
_____ Day _____ *DAY OF* _____ Month _____, *20*____ Year.

WITNESS NAME: Must be permanent employee _____

WITNESS TITLE: Must be permanent employee _____

HUMAN RESOURCES

LAST PAY WARRANT (Check)

In the event of your death, salary or other monies may be owed to you as an employee of our district. The form below permits immediate release of any warrants (checks) to a person you designate. This can often greatly assist in time of family stress or financial need. Please complete the form and return it to the district Office of Human Resources.

WARRANT RECIPIENT DESIGNATION

(Please Print or Type)

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

Name of DESIGNEE:_____ Relationship:_____

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

Telephone:_____

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

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

School District/Agency: Mt. San Antonio College

EMPLOYEE:_____ Date:_____

SIGNATURE:_____

HOW IS THE VACCINE ADMINISTERED?

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

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

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

No My assignment does not require occupational exposure to blood or body fluids.

No I have been vaccinated and/or have had Hepatitis B.

No I have been informed of the above matter. I do not wish to participate in the Hepatitis B vaccination program.

Circle one choice only

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

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

Signature: _____ Date: _____

Print name: _____

Department: _____

Position: _____

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

Mt. San Antonio College
EMPLOYEE ASBESTOS NOTIFICATION

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

_____ _____
Print Name Date

_____
Signature

Mt. San Antonio College

FAMILY CARE AND MEDICAL LEAVE

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

_____ _____

Print Name Date

_____

Signature

Mt. San Antonio College

COLLEGE NON-DISCRIMINATION STATEMENT

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

_____ _____

Print Name Date

_____

Signature

Mt. San Antonio College
COLLEGE DRUG FREE POLICY

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

_____ _____
Print Name Date

_____
Signature

Mt. San Antonio College

REASONABLE ACCOMMODATION

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

_____ _____
Print Name Date

_____
Signature

Mt. San Antonio College

SEXUAL HARASSMENT POLICY

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

_____ _____

Print Name Date

_____

Signature

Signature Page: Dissemination and User Acknowledgment:

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

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

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

Name: _____
Print Name

Name: _____ Date: _____
Signature

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

NOTICE OF EXCLUSION FROM CalPERS MEMBERSHIP

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

2. CURRENT NAME (LAST) (FIRST) (MIDDLE)

3. NAME OF PUBLIC AGENCY MT. SAN ANTONIO COLLEGE	4. DEPARTMENT OR SCHOOL DISTRICT	5. JOB OR POSITION TITLE
6. TERM OF APPOINTMENT ◯ PERMANENT ◯ TEMPORARY	7. IF TEMPORARY, ENTER NEAREST NUMBER OF WHOLE MONTHS THE APPOINTMENT IS EXPECTED TO LAST. MONTHS	8. APPOINTMENT DATE MM | DD | YYYY Start date

9. TIME BASE
◯ FULL-TIME ◯ INDETERMINATE ◯ PART-TIME IF PART TIME, ENTER THE FRACTION OF FULL TIME:

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

Choose one

☐ 1. Your full-time seasonal or limited term appointment is limited to 6 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) this fiscal year.

☐ 4. Your position is excluded by law or by contract agreement which excludes:
_____ Enter contract exclusion (for Public Agencies only).

☐ 5. You are an independent contractor.

☐ 6. You are employed to render professional legal service to a city.
Exceptions: Persons holding the office of city attorney, deputy city attorney, or assistant city attorney.

☐ 7. You are employed as a student aide by a school district in a position established for students only and you are attending school in the same district (for County Schools only).

NOTE: If you are a member of CalPERS by previous employment (either you have funds on deposit or service credit), exclusions 1, 2, and 3 do not apply to you and you should be a member in your present position. Be sure to notify your employer to complete a (PERS-1) Member Action Request Form or appoint via ACES to report your employment to CalPERS.

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

SIGNATURE OF CERTIFYING OFFICER	TITLE	DATE
HR ONLY	HR ONLY	HR ONLY
SIGNATURE OF EMPLOYEE		DATE

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

Complete if prior membership exists

California Public Employees' Retirement System
P.O. Box 942709 Sacramento, CA 94229-2709
888 CalPERS (or **888**-225-7377)
TTY: (877) 249-7442 | Fax: (916) 795-4166
www.calpers.ca.gov

RECIPROCAL SELF-CERTIFICATION FORM

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

Employee Name	(Last)	(First)	(Middle)
Date of Birth:		CalPERS ID:	

Check the applicable statement:

Choose one

☐ I have not been a member of a qualifying Public Retirement System in California.

☐ I have prior membership under another Public Retirement System in California. *(Complete the box below with verified dates including month, date, and year.* ***If you are unsure of the dates, please contact the Public Retirement System to confirm information prior to completing form****.)*

Name of Most Recent Reciprocal System:	Membership Date: / /	Separation Date*: / /	☐ Retired* ☐ Refunded* Date: / /
Name of Prior Reciprocal System:	Membership Date: / /	Separation Date*: / /	☐ Retired* ☐ Refunded* Date: / /
Name of Prior Reciprocal System:	Membership Date: / /	Separation Date*: / /	☐ Retired* ☐ Refunded* Date: / /

**Please provide dates, if applicable. Not all sections may be applicable for each Reciprocal System.*

I understand that by accepting employment in a qualified retirement system, I am subject to the applicable laws and regulations of that system. I also understand that completing this form does not constitute a request to establish reciprocity.

I hereby certify that the foregoing information has been verified as true and correct and any information found to be incorrect may require corrections to my account in the California Public Employees' Retirement System including, but not limited to, my retirement enrollment level. CalPERS may make any necessary corrections to my account to ensure I am properly enrolled and eligible to receive the correct retirement benefits.

_____ _____

Employee Signature Date

TO BE COMPLETED BY EMPLOYER ONLY: *(Human Resources Use Only)*

Name of CalPERS Agency:	CalPERS Business Partner ID:	Employee's CalPERS Original Hire Date:
Mt. San Antonio College	1228489046	
Designee of Employer: (Print Name)	(Title)	Employee's CalPERS Membership Eligibility Date:
Designee's Signature:	(Date)	

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

Contact Risk Management if you have questions regarding this form (909)274-4230

Mt. San Antonio College

Workers' Compensation Pre-Designation of Personal Physician

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

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

Employee Name: _____

Employee Address: _____

City: _____ State: _____ Zip Code: _____

Choose one

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

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

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

Physician / Medical Group Address: _____

City: _____ State: _____ Zip Code: _____

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

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

Employee Signature: _____ Date: _____ / _____ / _____

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

PERSONAL PHYSICIAN ACKNOWLEDGEMENT

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

Physician's Name / Medical Group: _____

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

_____ _____ / _____ / _____

Physician or Designated Employee of the Physician or Medical Group Date

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

This form is optional. Contact payroll with any questions

Mt. San Antonio College
1100 North Grand Avenue
Walnut, California 91789-1399
www.mtsac.edu

Direct Deposit Authorization

Step 1

Check the Appropriate Box

☐ Employee	☐ Vendor	☐ Student (Financial Aid)

Check the Appropriate Box

☐ New Request	☐ Changed Information	☐ Cancel Direct Deposit

Step 2 **Employee/Student/Vendor Information**

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

Authorization

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

Disclosure Statement

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

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

ACCOUNT HOLDER SIGNATURE:		**DATE:**	

Step 3

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

Staple voided check here (**DO NOT** attach a deposit slip) **OR** Have bank representative complete here

Staple Here

TO BE COMPLETED BY YOUR BANK

NAME OF YOUR BANK:			
ACCOUNT HOLDER NAME(S):			
☐ CHECKING ☐ SAVINGS	ACCOUNT NUMBER:	ROUTING NUMBER:	
BANK REPRESENTATIVE NAME:			
BANK REPRESENTATIVE SIGNATURE:		DATE:	

Revised 10/31/16

For District Use Only Input by:_____ Date:_____