Employment Eligibility Verification

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

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

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

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

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

Last Name *(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): ____________

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

Employment Eligibility Verification

Department of Homeland Security

U.S. Citizenship and Immigration Services

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

Section 2. Employer or Authorized Representative Review and Verification

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

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

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

Additional Information

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

Last Name of Employer or Authorized Representative	First Name of Employer or Authorized Representative	Employer's Business or Organization Name
		College of the Canyons

Employer's Business or Organization Address (*Street Number and Name*)	City or Town	State	ZIP Code
26455 Rockwell Canyon Rd	**Santa Clarita**	**CA**	**91355**

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

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

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

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

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

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

LISTS OF ACCEPTABLE DOCUMENTS
All documents must be UNEXPIRED

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

LIST A
Documents that Establish Both Identity and Employment Authorization

1. U.S. Passport or U.S. Passport Card
2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)
3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa
4. Employment Authorization Document that contains a photograph (Form I-766)
5. For a nonimmigrant alien authorized to work for a specific employer because of his or her status:
   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.
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

OR

LIST B
Documents that Establish Identity

1. Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address
2. ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address
3. School ID card with a photograph
4. Voter's registration card
5. U.S. Military card or draft record
6. Military dependent's ID card
7. U.S. Coast Guard Merchant Mariner Card
8. Native American tribal document
9. Driver's license issued by a Canadian government authority

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

AND

LIST C
Documents that Establish Employment Authorization

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. Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240)
3. Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal
4. Native American tribal document
5. U.S. Citizen ID Card (Form I-197)
6. Identification Card for Use of Resident Citizen in the United States (Form I-179)
7. Employment authorization document issued by the Department of Homeland Security

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

Refer to the instructions for more information about acceptable receipts.

OATH OF ALLEGIANCE FOR PUBLIC EMPLOYEES OR OFFICERS

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

OATH OF ALLEGIANCE

"I, ______________________________, do solemnly swear (or affirm) that I will support and defend 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 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: ______________________________
(Use current payroll name)

Subscribed and affirmed to before me on this

________________ day of ______________, 20

Dr. Dianne G. Van Hook
Chancellor, Santa Clarita Community College District

Note: Complete and file with official in charge of office or school in which you are employed.

The Oath of Allegiance may be subscribed to before any notary public or any member of a board of education or board of trustees, superintendent, associate or assistant superintendent, junior college director or president, high school or elementary school principal (Education Code Section 4341), or other legally authorized officer.

Santa Clarita Community College District
26455 Rockwell Canyon Road
Santa Clarita, CA 91355

WARRANT(S) RECIPIENT DESIGNATION

Under the provisions of Section 53245 of the California Government Code, in the event of my death I hereby designate the following named person to be entitled to receive all warrants payable to me by the Santa Clarita Community College District had I survived:

Beneficiary Information

TYPE OR PRINT FULL NAME OF DESIGNEE	RELATIONSHIP TO EMPLOYEE
ADDRESS (NUMBER, STREET, CITY, STATE AND ZIP CODE)	
PHONE NUMBER	SOCIAL SECURITY NUMBER

Contingent Beneficiary Information

IF THE BENEFICIARY NAMED ABOVE IS NOT LIVING THEN PAY:	RELATIONSHIP TO EMPLOYEE
ADDRESS (NUMBER, STREET, CITY, STATE AND ZIP CODE)	
PHONE NUMBER	SOCIAL SECURITY NUMBER

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

It is expressly understood and agreed that the *Santa Clarita Community College District* is not obligated to deliver said warrants to the person designated hereinabove unless said designated person, within two years after the date of said warrant or warrants, claims said warrants from the *Santa Clarita Community College District* and provides to said *Santa Clarita Community College District* sufficient proof of identity pursuant to the provisions of Section 53245 of California Government Code.

TYPE OR PRINT FULL NAME OF EMPLOYEE	SIGNATURE OF EMPLOYEE
EMPLOYEE IDENTIFICATION NUMBER	DATE SIGNED

Acknowledgement of Board Policies And Administrative Procedures

I have received a copy of the following Santa Clarita Community College District, College of the Canyons:

- Board Policy 3410 "Nondiscrimination"
  Administrative Procedure 3410 "Nondiscrimination"
- Board Policy 3430 "Prohibition of Harassment"
  Administrative Procedure 3430 "Prohibition of Harassment"
  Administrative Procedure 3435 "Discrimination and Harassment Investigations"
- Board Policy 3510 "Workplace Violence Plan"
- Board Policy 3530 "Weapons on Campus"
- Board Policy 3550 "Drug Free Environment and Drug Prevention Program"
- Board Policy 7348 "Reasonable Accommodations for Employees / Applicants"
- Board Policy 815 "Computer and Network Use for Faculty, Staff and Administrators"
  IMPORTANT: It is extremely important that the confidentiality of District information is maintained. By accessing District computer resources you are agreeing to maintain confidentiality of that information as well as to abide by Board Policy 815 and all administrative procedures created in support of this policy.

Signature ______________________ Date

Please Print Name ______________________

Position ______________________

Acknowledgement

Employee Workplace Complaint Process

I have received a copy of the Santa Clarita Community College District, College of the Canyons, "Employee Workplace Complaint Process".

Signature ______________________________ Date ______________

Please Print Name ____

Position ____

Acknowledgement
Board Policy 5541.1
College Assistants

I have received a copy of the Santa Clarita Community College District, College of the Canyons, Board Policy 5541.1 "College Assistants".

I understand that is my responsibility to notify my supervisor(s) of multiple concurrent assignments on campus every applicable semester to allow for coordination of my work schedule. I understand my total daily work schedule cannot exceed eight (8) hours per day and cannot exceed 20 hours per week (during the Fall/Spring semester) or 37.5 hours per week (during the Winter/Summer sessions). Failure to inform my supervisor(s) of multiple concurrent assignments for every applicable semester may lead to the termination of my temporary work assignment(s).

______________________________ ______________

Signature Date

____

Please Print Name

PERSONAL DATA and
EMERGENCY CONTACT INFORMATION

NAME ______________________________ DATE: __________

POSITION ______________________________ DEPT __________

ADDRESS ______________________________

CITY ______________________ ZIP __________

TELEPHONE ______________________ ______________________

Home Business

______________________ ______________________

Cell Name of Cell Phone Provider

In the event of a campus emergency, which number would you prefer we contact first? (Please Circle One) Home Business Cell

---

Our office frequently has inquiries for home telephone numbers and/or addresses of personnel associated with the College. Please indicate which groups we may release your information to. If not checked, it is assumed that information may not be released.

	Home Telephone	Cellular Telephone	Address
Instructors and Staff			
Students			
Parents of Students			
Personal Calls			
Business Calls			
Staff Directory			
American Federation of Teachers			

Other Special Instructions: ______________________________

IN CASE OF EMERGENCY

1) Please Notify ______________________________

Relationship ______________________________

Telephone ______________________________

Home Alternate

2) Please Notify ______________________________

Relationship ______________________________

Telephone ______________________________

Home Alternate

Employee Signature: ______________________________

Name: ____________________

CONFIDENTIAL RECRUITMENT SOURCE INFORMATION

Santa Clarita Community College District/College of the Canyons

The Santa Clarita Community College District does not discriminate on the basis of race, religious creed, color, ethnic or national origin, ancestry, citizenship status, uniformed service member status, physical disability, mental disability, medical condition, marital status, sex, pregnancy, age, sexual orientation, gender identity, or any other protected basis under the law. In order for us to evaluate our recruitment practices, please take a few minutes to complete this voluntary survey. The information on this survey is for statistical purposes only and will not be used in making any employment related decision.

WHERE DID YOU LEARN ABOUT THIS POSITION?

- ❑ Agency
- ❑ California Community College Registry
- ❑ CareerBuilder.com
- ❑ Career Fair
- ❑ CASBO
- ❑ Chronicle of Higher Education – Print
- ❑ Chronicle of Higher Education - Online
- ❑ COC Email
- ❑ COC Employee Referral
- ❑ COC Job Hotline
- ❑ COC Mailing
- ❑ COC Website
- ❑ Daily News
- ❑ Edjoin.org
- ❑ Employment Development Dept (EDD)
- ❑ HERC
- ❑ HigherEdJobs.com
- ❑ Los Angeles Times
- ❑ Monster.com
- ❑ Professional Association Website (please specify) ____________________
- ❑ The Signal
- ❑ Trade Journal/Publ. (please specify) ____________________
- ❑ Walk-in
- ❑ Website – Other (please specify) ____________________
- ❑ Other (please specify) ____________________

GENDER

- ❑ Male
- ❑ Female
- ❑ I choose not to respond

DISABILTY STATUS

- ❑ I am disabled

(Physical or mental impairment which substantially limits one or more life activities, including any psychological disorder or condition, cosmetic disfigurement or anatomical loss.

VETERAN STATUS

- ❑ I am a veteran

HISPANIC ETHNICITY

Are you Hispanic or Latino?

- ❑ No, I am not Hispanic or Latino
- ❑ Yes, I am Hispanic or Latino
  - ❑ Mexican, Mexican-American, Chicano
  - ❑ Central American
  - ❑ South American
  - ❑ Hispanic Other

If you answered "Yes" to being of Hispanic or Latino ethnicity, please stop here.

RACE (Choose all that apply)

- ❑ American Indian or Alaskan Native
- ❑ Asian – Asian Indian
- ❑ Asian - Cambodian
- ❑ Asian – Chinese
- ❑ Asian – Filipino
- ❑ Asian - Japanese
- ❑ Asian – Korean
- ❑ Asian – Laotian
- ❑ Asian - Vietnamese
- ❑ Asian – Other Asian
- ❑ Black/African-American (not Hispanic)
- ❑ Guamanian
- ❑ Hawaiian
- ❑ Samoan
- ❑ White (not Hispanic)
- ❑ Pacific Islander
- ❑ Unknown
- ❑ I choose not to respond

☐ Administrator ☐ Faculty ☐ Classified x Adjunct ☐ Other

PRIME Advantage MPN Complete Written Employee Notification – Employee Acknowledgment
MPN Approval Number: 95-2561360-0224

Santa Clarita Community College District
PRIME Advantage Medical Network
A Medical Provider Network (MPN)

Date: ________________________

A safe working environment is our number one priority. However, should an accident or injury occur we want to ensure that our employees receive prompt effective medical treatment. Our goal is to assist injured employees in making a full recovery and returning to their job as soon as possible.

We currently participate in the ***PRIME Advantage Medical Network*** (MPN) which has been approved by the Department of Industrial Relations Division of Workers' Compensation.

Unless you have predesignated your personal primary treating physician that meets the requirements of L.C. 4600 [must be your personal physician (MD or DO) who previously directed your medical care, retains your medical history and who agrees to treat you for a work related injury) ***in writing*** prior to your work related injury, all medical treatment must be provided by a physician or provider within the medical provider network. The attached *"PRIME Advantage MPN Complete Written Employee Notification"* will explain, in detail, all of your rights including how to change physicians, request a second and third opinion and how to gain access to a list of participating providers.

For all work related injuries occurring on or after **01/09/16** medical treatment will be provided through the Medical Provider Network. For work related injuries that occur prior to **01/09/16** you will be notified, in writing, if your medical treatment will be transferred into the medical provider network.

The attached *"PRIME Advantage MPN Complete Written Employee Notification"* is being provided to you in compliance with state regulations. Please read the material carefully and contact **Maria Calderon at (661) 362-5563** in **Human Resources** or Keenan & Associates should you have any questions.

By signing below you are acknowledging that you have received and read the "*PRIME Advantage MPN Complete Written Employee Notification*".

____
Employee Name

____
Date

Form032014

College of the Canyons

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 4600 **to qualify as the 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, which operates an integrated multi-specialty medical group providing comprehensive medical services predominantly for non-occupational illnesses and injuries.

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

EMPLOYEE NAME & ADDRESS:

____

❑ **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.

Employee Signature: ______________________________ Date: ____________

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

Name of Physician or Medical Group ______________________________ Phone Number ______________

Address ____

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

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

____

Employee Signature: ______________________________ Date: ____________

A *Personal Physician* must be willing to be predesignated and treat you for a workers' compensation injury.

The remainder of this form is to be completed by your physician and returned to your Employer.

PERSONAL PHYSICIAN ACKNOWLEDGEMENT

Per Labor Code 4600 to qualify you must meet the criteria outlined above. You are not required to sign this form, however, if you or your designated employee, does not sign, 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).

PERSONAL PHYSICIAN OR MEDICAL GROUP NAME: ______________________________

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

______________________________ ______________

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

Please return completed form to:

SCCCD (College of the Canyons) 26455 Roockwell Cyn. Rd. Santa Clarita CA 91355 FAX (661) 362-5570

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

Employee Name ______________________ **Employee ID#** ______________________

Employer Name Santa Clarita Community College District College of the Canyons **Employer ID#** 95-2561360

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** ______________

NOTICE OF EXCLUSION FROM CalPERS MEMBERSHIP FOR STATE AGENCIES

1. SOCIAL SECURITY NUMBER	**Your employer is legislatively mandated to provide an employee benefit package which includes service retirement, death, and disability benefits through the California Public Employees' Retirement System.**

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

3. NAME OF DEPARTMENT	4. JOB OR POSITION TITLE

5. TERM OF APPOINTMENT	6. IF TEMPORARY, ENTER NEAREST NUMBER OF WHOLE MONTHS THE APPOINTMENT IS EXPECTED TO LAST.	7. APPOINTMENT DATE		
☐ PERMANENT ☐ TEMPORARY	MONTHS	MM	DD	YYYY

8. 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:

☐ 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.

☐ 5. You are an independent contractor (Personal Services Contract).

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 Personnel Action Request (PAR) transaction to report your employment to CalPERS.

If you believe that your employment does qualify you for CalPERS membership, ask your employer for an explanation. If you still have doubts, you may appeal directly to CalPERS by sending a letter to the Actuarial & Employer Services Branch, Member Transaction Unit, at P.O. Box 942709, Sacramento, CA 94229-2709, stating the reasons why you feel you should be a member.

SIGNATURE OF CERTIFYING OFFICER	TITLE	DATE
SIGNATURE OF EMPLOYEE		DATE

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

PERS-AESD-139S (7/04)