



# 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			
<p><b>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.</b></p>		<p>Check one of the following boxes to attest to your citizenship or immigration status (See page 2 and 3 of the instructions.):</p> <input type="checkbox"/> 1. A citizen of the United States <input type="checkbox"/> 2. A noncitizen national of the United States (See Instructions.) <input type="checkbox"/> 3. A lawful permanent resident (Enter USCIS or A-Number.) <input type="checkbox"/> 4. A noncitizen (other than <b>Item Numbers 2.</b> and <b>3.</b> above) authorized to work until (exp. date, if any)						
		<p>If you check <b>Item Number 4.</b>, enter one of these:</p>						
		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)	<p><b>Additional Information</b></p>    <p>Check here if you used an alternative procedure authorized by DHS to examine documents.</p>				
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)					

<p><b>Certification:</b> 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.</p>		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 College of the Canyons		Employer's Business or Organization Address, City or Town, State, ZIP Code 26455 Rockwell Canyon Rd, Santa Clarita, CA 91355

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
<ol style="list-style-type: none"> <li>1. U.S. Passport or U.S. Passport Card</li> <li>2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)</li> <li>3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa</li> <li>4. Employment Authorization Document that contains a photograph (Form I-766)</li> <li>5. For an individual temporarily authorized to work for a specific employer because of his or her status or parole:               <ol style="list-style-type: none"> <li>a. Foreign passport; and</li> <li>b. Form I-94 or Form I-94A that has the following:                   <ol style="list-style-type: none"> <li>(1) The same name as the passport; and</li> <li>(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.</li> </ol> </li> </ol> </li> <li>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</li> </ol>	OR	<ol style="list-style-type: none"> <li>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</li> <li>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</li> <li>3. School ID card with a photograph</li> <li>4. Voter's registration card</li> <li>5. U.S. Military card or draft record</li> <li>6. Military dependent's ID card</li> <li>7. U.S. Coast Guard Merchant Mariner Card</li> <li>8. Native American tribal document</li> <li>9. Driver's license issued by a Canadian government authority</li> <li style="text-align: center;"><b>For persons under age 18 who are unable to present a document listed above:</b></li> <li>10. School record or report card</li> <li>11. Clinic, doctor, or hospital record</li> <li>12. Day-care or nursery school record</li> </ol>	AND	<ol style="list-style-type: none"> <li>1. A Social Security Account Number card, unless the card includes one of the following restrictions:               <ol style="list-style-type: none"> <li>(1) NOT VALID FOR EMPLOYMENT</li> <li>(2) VALID FOR WORK ONLY WITH INS AUTHORIZATION</li> <li>(3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION</li> </ol> </li> <li>2. Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240)</li> <li>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</li> <li>4. Native American tribal document</li> <li>5. U.S. Citizen ID Card (Form I-197)</li> <li>6. Identification Card for Use of Resident Citizen in the United States (Form I-179)</li> <li>7. Employment authorization document issued by the Department of Homeland Security               <p style="margin-left: 20px;">For examples, see <a href="#">Section 7</a> and <a href="#">Section 13</a> of the M-274 on <a href="https://uscis.gov/i-9-central">uscis.gov/i-9-central</a>.</p> <p style="margin-left: 20px;">The Form I-766, Employment Authorization Document, is a List A, <b>Item Number 4</b>, document, not a List C document.</p> </li> </ol>
<p><b>Acceptable Receipts</b></p> <p>May be presented in lieu of a document listed above for a temporary period.</p> <p>For receipt validity dates, see the M-274.</p>				
<ul style="list-style-type: none"> <li>• Receipt for a replacement of a lost, stolen, or damaged List A document.</li> <li>• Form I-94 issued to a lawful permanent resident that contains an I-551 stamp and a photograph of the individual.</li> <li>• Form I-94 with "RE" notation or refugee stamp issued to a refugee.</li> </ul>	OR	<p>Receipt for a replacement of a lost, stolen, or damaged List B document.</p>	AND	<p>Receipt for a replacement of a lost, stolen, or damaged List C document.</p>

\*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 ( <i>Family Name</i> ) from <b>Section 1</b> .	First Name ( <i>Given Name</i> ) from <b>Section 1</b> .	Middle initial (if any) from <b>Section 1</b> .
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**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 ( <i>mm/dd/yyyy</i> )	
Last Name ( <i>Family Name</i> )		First Name ( <i>Given Name</i> )		Middle Initial ( <i>if any</i> )
Address ( <i>Street Number and Name</i> )		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 ( <i>mm/dd/yyyy</i> )	
Last Name ( <i>Family Name</i> )		First Name ( <i>Given Name</i> )		Middle Initial ( <i>if any</i> )
Address ( <i>Street Number and Name</i> )		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 ( <i>mm/dd/yyyy</i> )	
Last Name ( <i>Family Name</i> )		First Name ( <i>Given Name</i> )		Middle Initial ( <i>if any</i> )
Address ( <i>Street Number and Name</i> )		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 ( <i>mm/dd/yyyy</i> )	
Last Name ( <i>Family Name</i> )		First Name ( <i>Given Name</i> )		Middle Initial ( <i>if any</i> )
Address ( <i>Street Number and Name</i> )		City or Town	State	ZIP Code



## 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.

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### 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\_\_

  
\_\_\_\_\_  
Mr. David C. Andrus, J.D.

Acting Chancellor, Santa Clarita Community College District and  
President, College of the Canyons

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

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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

College Assistant

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

College Assistant

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 it 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).

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**Signature**

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**Date**

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**Please Print Name**



## **Acknowledgement of Notice Regarding Required Trainings for new College Assistants and Short-Term Hourly Employees**

The Santa Clarita Community College District is committed to providing a safe and inclusive environment for our students, staff, faculty, and visitors. In accordance with federal, state, local, and District regulations and policies all new District employees are required to complete various trainings. The District has partnered with vendors to provide the asynchronous virtual trainings for employees. All new District employees are required to complete the following trainings:

- Sexual harassment/discrimination training via EverFi/Foundry (60 minutes in length)
- Protecting Youth via EverFi/Foundry (60 minutes in length)
- Injury and Illness Prevention Program via Keenan SafeColleges (15 minutes in length)
- Certain disciplines are required to complete additional trainings via Keenan SafeColleges as well (ex. Bloodborne Pathogen, Heat Illness Prevention, and PPE training for faculty in the health sciences).

All new employees are invited to both the EverFi/Foundry and Keenan platforms shortly after beginning their employment at the District. Employees are expected to complete the trainings within thirty (30) days of receipt of the invitation email.

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Signature

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Date

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Please Print Name

College Assistant

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Position



PERSONAL DATA and EMERGENCY CONTACT INFORMATION

NAME \_\_\_\_\_ DATE: \_\_\_\_\_

POSITION College Assistant 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.

Table with 4 columns: Group, Home Telephone, Cellular Telephone, Address. Rows include 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: \_\_\_\_\_

**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

**DISABILITY 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

**PRIME Advantage MPN Complete Written Employee Notification – Employee Acknowledgment**  
**MPN Identification Number: 2358**

**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 **Rian Medlin at (661) 362-3424** 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**

# 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](http://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

## 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
		College Assistant

**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:**

- Your full time seasonal or limited term appointment is limited to six months or less.
- Your part time appointment is limited to less than an average of 20 hours per week for less than one year.
- 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).
- Your position is excluded by law. Explain the exclusion that applies below:  
 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.)
- You are an independent contractor.
- 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.
- 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.)
- 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

Director of Volunteer Bureau  
and Student Employment

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Signature of Certifying Officer

Title

Date

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Signature of Employee

Date

**Note:** Information regarding the benefits provided by CalPERS is available on the CalPERS website [www.calpers.ca.gov](http://www.calpers.ca.gov).

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

# CalPERS Privacy Notice

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## 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**).