SAN MATEO COUNTY COMMUNITY COLLEGE DISTRICT
Cañada College • College of San Mateo • Skyline College

Office of Human Resources
3401 CSM Drive
San Mateo, CA 94402
Tel: (650) 574-6555
Fax: (650) 574-6574

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NEW ADJUNCT FACULTY WELCOME PACKET

Dear New Adjunct Faculty Member:

Welcome and congratulations on your selection as an adjunct member of the San Mateo County Community College District. Your Faculty Dean and Division staff will assist you with an orientation to your teaching assignment.

It is very important for you to note that we are unable to complete the employment process and place you on the payroll until you have completed the required paperwork and documentation listed below. If you have any questions about the employment paperwork, please contact your division office:

A. Documents to be submitted to your administrator before any classroom instruction begins:

- ☐ New Hire Information Form
- ☐ Employment Eligibility Verification I-9 Form
- ☐ Copy of documents shown from I-9
- ☐ Copy of Social Security Card
- ☐ W-4 Employee's Withholding Allowance Certificate
- ☐ EDD Employee's WithholdingAllowance Certificate
- ☐ AFT Union Information
- ☐ Payroll Direct Deposit Form
- ☐ Request for Verification of PT Faculty Employment
- ☐ New Employee Demographics
- ☐ Emergency Contact / Loyalty Oath
- ☐ Fingerprinting Livescan/Tuberculosis Procedures
- ☐ Fingerprinting Appointment Date: _____
- ☐ Tuberculosis Appointment Date: _____
- ☐ Proof of Freedom from Tuberculosis Results
- ☐ Conviction Info/W-2 Electronic Form Consent
- ☐ Mandated Reporting Child/Elder Neglect/Abuse
- ☐
- ☐ Predesignated Personal Physician Form
- ☐ New Hire Worker's Compensation Notice
- ☐ District Employment On-line Application
- ☐ Current Resume or Curriculum Vitae
- ☐ Copies of transcripts

Retirement

- ☐ SMCCCD STRS/PERS/SS/Medicare Related Form A
- ☐ CALSTRS Cash Balance Benefit Program
- ☐ CALSTRS Pemissive Membership
- ☐ Social Security Form SSA

Optional: Part-Time Faculty Health Benefits

- ☐ Adjunct Medical Reimbursement Program
- ☐ Adjunct Flexible IRC 125 Benefit Program
- ☐ Choose Cash Balance Booklet
- ☐ Prescription Discount Plan

A. Please visit Frequently Asked Questions: Employee ID Badge. https://smccd-public.sharepoint.com/humanresources/Employee_Badge_FAQ.pdf

B. Please contact the Campus Bookstore to schedule your fingerprinting appointments. The fingerprinting receipt must be returned to the Campus Payroll. You must complete your fingerprinting and tuberculosis exam prior to your first day of employment.

C. You are entitled to sick leave accrual provided at the end of each semester. Your accrual rate is prorated per a full time equivalent load. It is your responsibility to report your absences of paid leave used in your absence affidavit at the end of each month. The absence affidavit form is available in the District Portal Website, Downloads, Human Resources Folder.

* Verification of membership in the California Bar Association must be by official documentation certifying that the employee is eligible to practice law in the State of California.

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3401 CSM Drive – San Mateo, CA 94402
Automated Service Line: (650) 574-6555
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NEW HIRE INFORMATION FORM

☐ Skyline College ☐ College of San Mateo ☐ Cañada College ☐ Chancellor's Office

Print Employee Name (last name, first name): _____/_____/_____ **G#:**_ _ _ _ _ _ _ _ _ _
Last First Middle
(must be the same as shown on the soc sec card)

Birth date: _____

Street Address: _____ **Apt #:** _____

City, State, Zip Code: _____

E-mail Address: _____ **Cell Phone #:**

Retirement System Membership

Are you currently employed by another public agency (by a city, county or another public school system)?

☐ **NO:** If you have previously been employed by another public agency, on what date did your employment end? _____

Name of the public agency/school district: _____

☐ **YES**: Name of current public agency/school district: _____ ☐ **Full time** ☐ **Part time**

If YES, Will you continue your employment at this public agency while you are working for the District?

☐ **Yes:** (Note: your dual public employment will directly affect the amount of service credit that you will receive from your retirement system)
☐ **No:** I will end my employment with this agency on (date): _____

Have you ever been employed at any San Mateo County School? ☐ **YES** ☐ **NO**

If yes, Please indicate school district? _____ ☐ **Certificated** ☐ **Classified**

Have you ever been a member of a California retirement system? ☐ **YES** ☐ **NO**

If YES, what is the name of it?
☐ Public Employees' Retirement System (PERS)
☐ State Teachers' Retirement System (STRS)
☐ Other: Name: _____

If you have been a member of either PERS or STRS, have you ever received a refund of your contributions?

☐ **NO** ☐ **YES, refund received on _____**

Have you ever retired from either PERS or STRS? ☐ **NO** ☐ **YES,** on (date) _____

All of the information provided on this form is true and accurate to the best of my knowledge.

Employee Signature: _____ **Date:** _____

Department Dean:

New Hire Start Date: _____ **New Hire Column:**_____ **New Hire Step:** _____

New Hire Dept/Div: _____ **Dean's Signature:** _____ **Date:**_____

Verified by HR: _____ **Date:**_____

Employment Eligibility Verification

Department of Homeland Security

U.S. Citizenship and Immigration Services

USCIS Form I-9

OMB No.1615-0047

Expires 07/31/2026

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Additional Information

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

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

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

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

Employer's Business or Organization Name	Employer's Business or Organization Address, City or Town, State, ZIP Code

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

LISTS OF ACCEPTABLE DOCUMENTS

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

LIST A Documents that Establish Both Identity and Employment Authorization	OR	LIST B Documents that Establish Identity	AND	LIST C Documents that Establish Employment Authorization
1. U.S. Passport or U.S. Passport Card		**1.** Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		**1.** A Social Security Account Number card, unless the card includes one of the following restrictions: **(1)** NOT VALID FOR EMPLOYMENT **(2)** VALID FOR WORK ONLY WITH INS AUTHORIZATION **(3)** VALID FOR WORK ONLY WITH DHS AUTHORIZATION
2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)		**2.** ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		**2.** Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240)
3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa		**3.** School ID card with a photograph		**3.** Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal
4. Employment Authorization Document that contains a photograph (Form I-766)		**4.** Voter's registration card		**4.** Native American tribal document
5. For an individual temporarily authorized to work for a specific employer because of his or her status or parole: **a.** Foreign passport; and **b.** Form I-94 or Form I-94A that has the following: **(1)** The same name as the passport; and **(2)** An endorsement of the individual's status or parole as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form.		**5.** U.S. Military card or draft record		**5.** U.S. Citizen ID Card (Form I-197)
		6. Military dependent's ID card		**6.** Identification Card for Use of Resident Citizen in the United States (Form I-179)
		7. U.S. Coast Guard Merchant Mariner Card		**7.** Employment authorization document issued by the Department of Homeland Security For examples, see **Section 7** and **Section 13** of the M-274 on **uscis.gov/i-9-central**. The Form I-766, Employment Authorization Document, is a List A, **Item Number 4.** document, not a List C document.
		8. Native American tribal document		
		9. Driver's license issued by a Canadian government authority		
		For persons under age 18 who are unable to present a document listed above:		
		10. School record or report card		
		11. Clinic, doctor, or hospital record		
		12. Day-care or nursery school record		
6. Passport from the Federated States of Micronesia (FSM) or the Republic of the Marshall Islands (RMI) with Form I-94 or Form I-94A indicating nonimmigrant admission under the Compact of Free Association Between the United States and the FSM or RMI				

Acceptable Receipts

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Supplement B,
Reverification and Rehire (formerly Section 3)

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

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

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

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

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

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

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

I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented documentation, the documentation I examined appears to be genuine and to relate to the individual who presented it.

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

Additional Information (Initial and date each notation.)

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

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

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

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

I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented documentation, the documentation I examined appears to be genuine and to relate to the individual who presented it.

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

Additional Information (Initial and date each notation.)

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

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

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

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

I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented documentation, the documentation I examined appears to be genuine and to relate to the individual who presented it.

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

Additional Information (Initial and date each notation.)

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

Employment Development Department
State of California

Clear Form

Employee's Withholding Allowance Certificate

Complete this form so that your employer can withhold the correct California state income tax from your paycheck.

Enter Personal Information	
First, Middle, Last Name	Social Security Number
Address City State ZIP Code	Filing Status ☐ Single or Married (with two or more incomes) ☐ Married (one income) ☐ Head of Household

1. Use Worksheet A for Regular Withholding allowances. Use other worksheets on the following pages as applicable.
   - 1a. Number of Regular Withholding Allowances (**Worksheet A**) 0
   - 1b. Number of allowances from the Estimated Deductions (**Worksheet B**, if applicable.) 0
   - 1c. Total Number of Allowances you are claiming 0
2. Additional amount, if any, you want withheld each pay period (if employer agrees), **(Worksheet C)**

OR

Exemption from Withholding

3. I claim exemption from withholding for 2024, and I certify I meet both of the conditions for exemption. (Check box here) ☐

OR

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

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

Employee's Signature _____ Date _____

Employer's Section: Employer's Name and Address	California Employer Payroll Tax Account Number
San Mateo Community College District 3401 CSM DR San Mateo, CA 94402	814-7296-1

Purpose: The *Employee's Withholding Allowance Certificate* (DE 4) is for **California Personal Income Tax (PIT)** withholding purposes only. The DE 4 is used to compute the amount of taxes to be withheld from your wages, by your employer, to accurately reflect your state tax withholding obligation.

Beginning January 1, 2020, *Employee's Withholding Allowance Certificate* (Form W-4) from the Internal Revenue Service (IRS) will be used for federal income tax withholding **only**. You must file the state form DE 4 to determine the appropriate California PIT withholding.

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

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

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

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

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

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

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

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

(iii) You maintain your domicile in another state.

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

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

2024

Step 1: Enter Personal Information

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

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

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

Step 2: Multiple Jobs or Spouse Works

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

Do **only one** of the following.

(a) Use the estimator at *www.irs.gov/W4App* for most accurate withholding for this step (and Steps 3–4). If you or your spouse have self-employment income, use this option; **or**

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

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

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

Step 3: Claim Dependent and Other Credits

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

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

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

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

Step 4 (optional): Other Adjustments

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

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

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

Step 5: Sign Here

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

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

Employers Only

Employer's name and address	First date of employment	Employer identification number (EIN)
San Mateo Community College District 3401 CSM DR San Mateo, CA 94402		94-3084147

CALSTRS Defined Benefit Plan? CALSTRS Cash Balance Plan? Or Social Security?

An Adjunct can choose between a CalSTRS Defined Benefit Plan, CalSTRS Cash Balance Plan or Social Security.

- **What is a Defined Benefit plan?** The Defined Benefit Plan provides a specific monthly benefit at! retirement that is predetermined by a formula, rather than depending directly on investment returns. To! be vested in the Defined Benefit Plan you must have 5 years of full time credited service. The Defined! Benefit Plan formula is service credit x age factor x final compensation = retirement benefit. For! additional information about the Defined Benefit Plan: **http://www.calstrs.com/calstrs-member-handbook or call 1-800-228-5453.**

- **What is the Cash Balance Benefit Program?** The Cash Balance Benefit Program, an Internal Revenue Code 401 (a) defined benefit plan, is designed specifically for part-time educators and adjunct faculty. Eligibility is determined on the basis of employment (part-time or temporary employment), not on the actual hours worked. Generally, employees and employers each contribute 4 percent of the employee's gross salary. The Cash Balance Benefit Program is a hybrid retirement program that can be an alternative to the CASLTRS Defined Benefit Program, Social Security and other retirement plans. It accumulates funds based on dollars contributed by the employee and the employer plus interest, similar to a defined contribution program. But like a defined benefit plan, it offers a guaranteed benefit – a lump sum, or in monthly annuity payments if the balance is at least $3,500. If you are not a member of any pension plan or Social Security – the employee could receive a small pension. The amount is based on dollars put into the system vs time worked. Vesting is immediate. For additional information about the Cash Balance Benefit Program: http://www.calstrs.com/publication/cash-balance-benefit-program-retirement-plan-part-time-and-adjunct-educators, or call 1-800-228-5453.

  When an employee is vested in the Defined Benefit Plan or the Cash Balance benefit Program, the employee may be affected by the Windfall Elimination Provision and the Government Pension Offset.

  - **The Windfall Elimination Provision (WEP)** reduces the amount of your Social Security benefit when you work a job that does not take out Social Security taxes from your paycheck. The WEP does have an exception that with 30 years or more of substantial earning there is no reduction to your Social Security payment or a guarantee that with a relatively low pension, the reduction to your Social Security benefit cannot be more than ½ of the amount of your pension. **http://www.ssa.gov/pubs/EN-05-10045.pdf**
  - **The Government Offset** could reduce the amount of payment to you that you may receive from your spouse's, widow's or widower's Social Security benefit. **http://www.ssa.gov/pubs/EN-05-10007.pdf**

- **What is Social Security?** Social Security provides monthly cash benefits to retired workers, their spouses, dependent children, and survivors of deceased workers (spouses, dependent children, and dependent parents). Payment is based on your age and years of contribution.
  For additional information about Social Security Benefits: http://www.ssa.gov/ or call 1-800-772-1213.

Forms to be completed:

Cash Balance Benefit Program

- Form A
- CB 533 – Cash Balance Election
- Form SSA – 1945 Statement Concerning your employment in a job not Covered by Social Security
- CALSTRS Permissive Membership

Defined Benefit Plan

- Form A
- CB533 – Cash Balance Election Permissive Membership form ES 0350
- Form SSA – 1945 Statement Concerning your employment in a job not Covered by Social Security
- CALSTRS Permissive Membership

Social Security

- Form A
- CB533 Cash Balance Election
- CALSTRS Permissive Membership

CALPERS

- Form A

  (*Must meet the following requirements: A member of CalPERS who is employed by a school employer, Board of Governors of Community College Districts or State Department of Education or has at least five years of CalPERS credited service, as defined in Government Code Section 20309, and who subsequently becomes employed to perform creditable service that requires membership in CALSTRS, will have that service credited with CALSTRS unless he/she files a written election (within 60 days of the date of hire in the new position) to have the service credited with CalPERS.)*

SAN MATEO COUNTY COMMUNITY COLLEGE DISTRICT
Cañada College • College of San Mateo • Skyline College

Office of Human Resources
3401 CSM Drive, San Mateo, CA 94402
Automated Service Line: (650) 574-6555
Fax: (650) 574-6574

FORM A

(to be completed by all adjunct faculty)

☐ I am currently an active member of a California public retirement system:

- ☐ State Teachers' Retirement System (STRS)
- ☐ Public Employees' Retirement System (PERS)

Name of employing agency when membership began: _____

OR

☐ I am not currently an active member of a California public retirement system and I wish to elect voluntary membership in the **State Teachers' Cash Balance Retirement System**. Enclosed is my completed voluntary STRS Cash Balance membership election form.

OR

☐ I am not currently an active member of a California public retirement system and I wish to elect voluntary membership in the **State Teachers' Defined Retirement System**. Enclosed is my completed voluntary STRS Defined membership election form.

OR

☐ I am not currently an active member of a California public retirement system. I elect participation in the **Social Security/Medicare program** and understand that 7.65% of my earnings will be deducted each month for services performed.

Social Security
1-800-772-1213
1-800-325-0778 (TTY)
Monday – Friday 7:00am – 7:00pm

STRS
1-800-228-5453
1-800-229-3541 (TTY)
Monday – Friday 8:00am – 5:00pm

Employee Name _____ Employee Signature _____ Date _____

Cash Balance Benefit Program Election - Instructions

CALSTRS

SECTION 1: EMPLOYEE INFORMATION
Provide the following information:

- CalSTRS Client ID or Social Security Number
- Last Name, First Name and Middle Initial
- Mailing Address, City, State and Zip Code
- Date of Birth
- Email Address
- Home Telephone

SECTION 2: ELECTION (TO BE COMPLETED BY EMPLOYEE)
Complete Section 2.1, 2.2 or 2.3 depending on which section applies to you. If you are unsure or need assistance completing one of these sections, please work with your employer.

SECTION 2.1: CALSTRS DEFINED BENEFIT PROGRAM MEMBER
If you are a member of the Defined Benefit Program your creditable service defaults to coverage by the Defined Benefit Program.

You may elect Cash Balance Benefit Program coverage in lieu of Defined Benefit Program coverage for eligible creditable service performed for an employer that offers the Cash Balance Benefit Program. Your election must be made within 60 days of your date of employment in the Cash Balance Benefit Program eligible position, or the date or effective date of your employer's action to provide the Cash Balance Benefit Program, whichever is later. Your election is effective the first day of employment in the Cash Balance Benefit Program eligible position or the effective date of your employer's action to provide the Cash Balance Benefit Program, whichever is later.

If you elect coverage by the Cash Balance Benefit Program, you may later elect that future creditable service performed for that employer be subject to coverage by the Defined Benefit Program. You may make that election at any time while employed to perform creditable service. This election may be effective no earlier than the first day of the pay period in which your election is made.

SECTION 2.2: CALSTRS DEFINED BENEFIT PROGRAM NON-MEMBER
If you are not a member of the Defined Benefit Program, your eligible creditable service defaults to coverage by the Cash Balance Benefit Program as of the first day you perform creditable service for your employer or the effective date of your employer's action to provide the Cash Balance Benefit Program, whichever is later.

You may elect coverage by an alternative retirement plan, including Social Security, offered by your employer in lieu of participating in the Cash Balance Benefit Program if your employer's action to provide the program allows. Your election must be made within 60 days of your first day of creditable service, or the date or effective date of your employer's action to provide the Cash Balance Benefit Program, whichever is later.

If Social Security was not available when your service defaulted to coverage by the Cash Balance Benefit Program and Social Security is later provided by your employer, you may elect Social Security coverage. Your election must be made within 60 days of the date or effective date of your employer's action to provide Social Security, whichever is later. If you make this election, your eligible creditable service will be subject to coverage by Social Security on the effective date of your employer's action to provide Social Security and your participation in the Cash Balance Benefit Program for that employer will end the day prior.

If you elect coverage by Social Security or another alternative retirement plan offered by your employer, you may subsequently elect coverage by the Cash Balance Benefit Program for future creditable service performed for that employer so long as you are employed to perform creditable service and your basis of employment is eligible for participation. This election can be effective no earlier than the first day of the pay period in which the election is made.

You may elect membership in the Defined Benefit Program using the *Permissive Membership* (ES 350) form at any time while employed to perform creditable service.

SECTION 2.3: TRUSTEE SERVICE
If you are performing service as a trustee for an employer that offers the Cash Balance Benefit Program, you may elect coverage by the program for your trustee service. Your election can be effective no earlier than the first day of the pay period in which your election is made.

SECTION 3: REQUIRED SIGNATURE (TO BE COMPLETED BY EMPLOYEE)
Sign the form and date your signature.

SECTION 4: EMPLOYER INFORMATION AND CERTIFICATION (TO BE COMPLETED BY EMPLOYER)

Provide the following information:

- The employer (district) name
- County and district code
- Name and title of employer official reviewing form

Verify Sections 1 through Section 3 are completed, and that the employee is eligible for any elections made or effective dates provided.

Sign the form, date your signature, submit the form to CalSTRS and retain a copy.

SUBMIT

CalSTRS must receive this form within 60 days after the employee's signature date.

Secure Employer Website:	Send the completed form to the ES Forms Queue found in the Business Areas dropdown of the Recipient via SEW.
Email to:	Submit this form via email to the esforms@calstrs.com mailbox unless otherwise instructed by your CalSTRS representative. If sending forms to the esforms@calstrs.com mailbox, please remove all Social Security numbers and only provide the Client ID where applicable.
Mail to:	CalSTRS P.O. Box 15275, MS 17 Sacramento, CA 95851-0275

QUESTIONS

Employee – contact your employer.

Employer – contact your CalSTRS Employer Services Representative.

Cash Balance Benefit Program Election

CB 533 REV 04/23

[For CalSTRS' Official Use Only]

California State Teachers' Retirement System
P.O. Box 15275, MS17
Sacramento, CA 95851-0275
800-228-5453
CalSTRS.com

COVERAGE ELECTION FOR A CASH BALANCE BENEFIT PROGRAM EMPLOYER AND/OR ACKNOWLEDGEMENT OF RECEIPT OF COVERAGE INFORMATION

Instructions: This form is used to make a coverage election for creditable service performed for a Cash Balance Benefit Program employer and/or to acknowledge receipt of information related to available coverage options.

Section 1: Employee Information

Provide either your Client ID or Social Security number.

CLIENT ID

SOCIAL SECURITY NUMBER ___ - ___ - ____

LAST NAME

FIRST NAME MI

MAILING ADDRESS

CITY STATE ZIP CODE

DATE OF BIRTH (MM/DD/YYYY)

EMAIL ADDRESS

HOME TELEPHONE

Section 2: Election (to be completed by employee)

Complete Section 2.1, 2.2 or 2.3 depending on which section applies to you. If you are unsure or need assistance completing one of these sections, please work with your employer.

Section 2.1 CalSTRS Defined Benefit Program MEMBER (check one):

☐ I decline Cash Balance Benefit Program coverage for eligible creditable service performed for this employer. I understand eligible service will default to Defined Benefit Program coverage.

☐ I elect Cash Balance Benefit Program coverage for eligible creditable service preformed for this employer. I understand my election is effective the first day of employment in the Cash Balance Benefit Program eligible position, or the date or effective date of my employer's action to provide the Cash Balance Benefit Program, whichever is later.

☐ I previously elected Cash Balance Benefit Program coverage for creditable service performed for this employer and now elect Defined Benefit Program coverage for creditable service performed for this employer as of: _____

EFFECTIVE DATE (MM/DD/YYYY)*

*Effective Date can be no earlier than the first day of the pay period in which this election is made.

CB533

Section 2.2 CalSTRS Defined Benefit Program NON-MEMBER (check one):

☐ I decline alternative retirement plan coverage for eligible creditable service performed for this employer, or no such coverage is offered by my employer. I understand eligible service will default to Cash Balance Benefit Program coverage.

☐ I elect alternative retirement plan coverage for eligible creditable service performed for this employer. I understand my election is effective the first day creditable service is performed in the eligible position or the date or effective date of my employer's action to provide the alternative retirement plan, whichever is later.

☐ I previously elected alternative retirement plan coverage for creditable service performed for this employer and now elect Cash Balance Benefit Program coverage for creditable service performed for this employer as of: _____

EFFECTIVE DATE (MM/DD/YYYY)*

Section 2.3 Trustee Service (form is only required to elect coverage):

☐ I elect Cash Balance Benefit Program coverage for trustee service performed for this employer as of: _____

EFFECTIVE DATE (MM/DD/YYY)*

*Effective Date can be no earlier than the first day of the pay period in which this election is made.

Section 3: Required Signature (to be completed by employee)

I certify that my employer provided me information about the available coverages for my creditable service and my rights and responsibilities.

I understand it is a crime to fail to disclose a material fact or to make any knowingly false material statement for the purpose of using it, or allowing it to be used, to obtain, receive, continue, increase, deny or reduce any benefit administered by CalSTRS and it may result in penalties, including restitution, of up to one year in jail and/or a fine of up to $5,000 (Education Code section 22010). It may also result in any document containing such false representation being voided. I certify under penalty of perjury under the laws of the State of California that the foregoing is true and correct. I understand that perjury is punishable by imprisonment for up to four years (Penal Code section 126).

EMPLOYEE'S SIGNATURE	SIGNATURE DATE (MM/DD/YYYY)

Section 4: Employer Information and Certification (to be completed by employer)

I certify that the employee is eligible for the election and was provided required information about their coverage options.

I understand it is a crime to fail to disclose a material fact or to make any knowingly false material statement for the purpose of using it, or allowing it to be used, to obtain, receive, continue, increase, deny or reduce any benefit administered by CalSTRS and it may result in penalties, including restitution, of up to one year in jail and/or a fine of up to $5,000 (Education Code section 22010). It may also result in any document containing such false representation being voided. I certify under penalty of perjury under the laws of the State of California that the foregoing is true and correct. I understand that perjury is punishable by imprisonment for up to four years (Penal Code section 126).

EMPLOYER OFFICIAL'S SIGNATURE		SIGNATURE DATE (MM/DD/YYYY)
EMPLOYER NAME		COUNTY AND DISTRICT CODE
San Mateo Community College District	050	
EMPLOYER OFFICIAL'S NAME AND TITLE		

Permissive Membership - Instructions

If you are employed to perform creditable service in a position that is excluded from mandatory membership in the CalSTRS' Defined Benefit (DB) Program, you may use this form to elect DB Program membership at any time while employed to perform creditable service.

A permissive election of membership in the DB Program applies to all future creditable service performed for the same or another employer, including any non-member or CalSTRS Cash Balance Benefit (CB) Program service you are currently performing. You may be entitled to elect coverage by the CB Program or California Public Employees' Retirement System (CalPERS) for future eligible service as allowed by law. Please work with your employer if you believe you are entitled to make one of these elections.

A permissive election of membership in the DB Program is irrevocable. Membership may only be cancelled if you terminate all employment to perform creditable service and refund your accumulated retirement contributions from the CalSTRS DB Program.

SECTION 1: EMPLOYEE INFORMATION (TO BE COMPLETED BY EMPLOYEE)

Provide the following information:

- CalSTRS Client ID* or Social Security Number
- Last Name, First Name and Middle Initial
- Mailing Address**, City, State and Zip Code
- Date of Birth
- Email Address
- Telephone Number

*If you have already been employed to perform creditable service you will have a CalSTRS Client ID, even if you were not formerly a member. Please provide your CalSTRS Client ID, if you have one, in lieu of your Social Security Number.

**To establish residency for tax purposes, we ask that you provide a street address. Be sure to include any street, apartment or suite number. If your post office does not deliver mail to your street address, you may enter your box number instead. If you reside outside the United States, use the CITY – STATE – ZIP field to provide your foreign address. If you receive your mail in care of a third party, enter "c/o" followed by the third party's name and address.

SECTION 2: EMPLOYEE ELECTION (TO BE COMPLETED BY EMPLOYEE)

If you want to elect membership in the CalSTRS DB Program:

- Check the appropriate box
- Provide your requested membership date***

***You will begin contributing to the DB Program as of your membership date. Your membership date can be no earlier than the first day of the pay period in which your election is made, or your first day of employment, whichever is later. Work with your employer to select the most beneficial, valid membership date you are eligible for. Electing an invalid membership date will require a revision to your election form and may result in delayed contributions to CalSTRS.

If you do not want to elect membership in the CalSTRS DB Program at this time, check the appropriate box.

SECTION 3: REQUIRED SIGNATURE (TO BE COMPLETED BY EMPLOYEE)

Sign the form and date your signature.
Return the form to your employer.

SECTION 4: EMPLOYEE POSITION INFORMATION (TO BE COMPLETED BY EMPLOYER)

Provide the position hire date – the date in which the employee was hired to perform creditable service in the position they are making this election for. CalSTRS defers to the employer as to the date in which you consider an employee to be hired. Provide the position title – the title of the position the employee is performing creditable service in.

SECTION 5: EMPLOYER INFORMATION AND CERTIFICATION (TO BE COMPLETED BY EMPLOYER)

Verify the employee is eligible for the requested membership date.

Provide the following information:

- The employer (county or district) name
- County and district code
- Name and title of employer official completing the form

Sign the form and date your signature.
Submit the form to CalSTRS and retain a copy.

Permissive Membership - Instructions

CALSTRS

SUBMIT

This form should be submitted to CalSTRS by the employer. CalSTRS must receive this form within 60 days after the employee's signature date and, if applicable, prior to the submission of contributions.

Secure Employer Website:	Send the completed form to the ES Forms Queue found in the Business Areas dropdown of the Recipient via SEW.
Email to:	Submit this form via email to the esforms@calstrs.com mailbox unless otherwise instructed by your CalSTRS representative. If sending forms to the esforms@calstrs.com mailbox, please remove all Social Security numbers and only provide the Client ID where applicable.
Mail to:	CalSTRS P.O. Box 15275, MS 17 Sacramento, CA 95851-0275

QUESTIONS

Employee – contact your employer

Employer – contact CalSTRS Employer Help

Permissive Membership

ES 0350 REV 04/23

[For CalSTRS' Official Use Only]

CALSTRS
California State Teachers' Retirement System
P.O. Box 15275, MS 17
Sacramento, CA 95851-0275
800-228-5453
CalSTRS.com

PERMISSIVE MEMBERSHIP ELECTION AND/OR ACKNOWLEDGEMENT OF RECEIPT OF CALSTRS DEFINED BENEFIT PROGRAM MEMBERSHIP INFORMATION

This form is used to permissively elect membership in the CalSTRS Defined Benefit Program and/or to acknowledge receipt of information provided by an employer about the right to elect membership in the CalSTRS Defined Benefit Program. Please read all instructions before completing the form.

Section 1: Employee Information (to be completed by employee)

Provide either your CalSTRS Client ID or Social Security number.

CLIENT ID

SOCIAL SECURITY NUMBER

LAST NAME

FIRST NAME

MI

ADDRESS (number, street, apt or suite no.)

CITY

STATE

ZIP CODE

DATE OF BIRTH (MM/DD/YYYY)

EMAIL ADDRESS

TELEPHONE

Section 2: Employee Election (to be completed by employee)

Check One:

☐ **I elect membership in the CalSTRS Defined Benefit Program as of:** _____

MEMBERSHIP DATE (MM/DD/YYYY)**

I understand this election applies to all future creditable service performed for any current or future employer unless another election is made as allowed by law. I understand my membership is irrevocable and may only be cancelled by terminating all employment to perform creditable service and receiving a refund of my accumulated retirement contributions from the CalSTRS Defined Benefit Program.

**Membership Date may be no earlier than the first day of the pay period in which the election is made, or the first day of employment, whichever is later. Please work with your employer to select the most beneficial, valid membership date.

☐ **I decline membership in the CalSTRS Defined Benefit Program at this time**

I understand that I can elect membership in the CalSTRS Defined Benefit Program at any time while I am employed to perform creditable service.

ES0350

Section 3: Required Signature (to be completed by employee)

I certify that I have received information from my employer concerning the CalSTRS Defined Benefit Program and understand the criteria for membership in the program.

I understand it is a crime to fail to disclose a material fact or to make any knowingly false material statement, including a false statement regarding my marital status, for the purpose of using it, or allowing it to be used, to obtain, receive, continue, increase, deny or reduce any benefit administered by CalSTRS and it may result in penalties, including restitution, of up to one year in jail and/or a fine of up to $5,000 (Education Code section 22010). It may also result in any document containing such false representation being voided. I certify under penalty of perjury under the laws of the State of California that the foregoing is true and correct. I understand that perjury is punishable by imprisonment for up to four years (Penal Code section 126).

EMPLOYEE SIGNATURE	DATE (MM/DD/YYYY)

Section 4: Employee Position Information (to be completed by employer)

POSITION TITLE	POSITION HIRE DATE

Section 5: Employer Information and Certification (to be completed by employer)

Required Signature

I certify that the above-named employee was provided information about their right to elect membership in the CalSTRS Defined Benefit Program and, if electing membership, is eligible to elect membership in the CalSTRS Defined Benefit Program as of the membership date provided.

I understand it is a crime to fail to disclose a material fact or to make any knowingly false material statement for the purpose of using it, or allowing it to be used, to obtain, receive, continue, increase, deny or reduce any benefit administered by CalSTRS and it may result in penalties, including restitution, of up to one year in jail and/or a fine of up to $5,000 (Education Code section 22010). It may also result in any document containing such false representation being voided. I certify under penalty of perjury under the laws of the State of California that the foregoing is true and correct. I understand that perjury is punishable by imprisonment for up to four years (Penal Code section 126).

EMPLOYER OFFICIAL'S SIGNATURE	DATE (MM/DD/YYYY)
EMPLOYER NAME	COUNTY AND DISTRICT CODE
San Mateo Community College District	050
EMPLOYER OFFICIAL'S NAME AND TITLE	

SAN MATEO COUNTY COMMUNITY COLLEGE DISTRICT
Cañada College • College of San Mateo • Skyline College

Office of Human Resources
3401 CSM Drive, San Mateo, CA 94402
Automated Service Line: (650) 574-6555
Fax: (650) 574-6574

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

Employee Name _____ **Employee ID#** _____

Employer Name San Mateo County Community College District **Employer ID#** 943084147

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

Windfall Elimination Provision

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

Government Pension Offset Provision

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

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

For More Information

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

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

Signature of Employee _____ **Date** _____

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

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

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

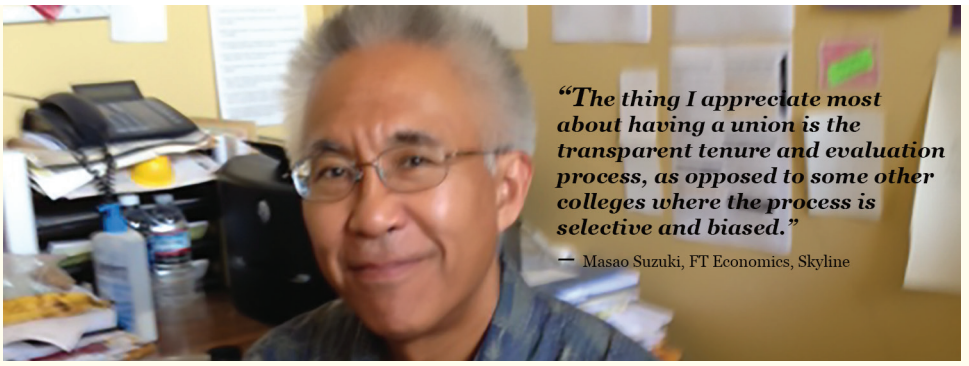
Employers must:

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

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

Copies of the SSA-1945 are available online at the Social Security website, www.socialsecurity.gov/online/ssa-1945.pdf. Paper copies can be requested by email at ofsm.oswm.rqct.orders@ssa.gov or by fax at 410-965-2037. The request must include the name, complete address and telephone number of the employer. Forms will not be sent to a post office box. Also, if appropriate, include the name of the person to whom the forms are to be delivered. The forms are available in packages of 25. Please refer to Inventory Control Number (ICN) 276950 when ordering.

SAN MATEO COMMUNITY COLLEGE FEDERATION OF TEACHERS 1493 afl-cio



AFT 1493 Membership Application Form

San Mateo Community College Federation of Teachers
AFT Local 1493, CFT, AFL-CIO

Join now and have a voice in your union!
To become an AFT 1493 member, please fill out this form and return it to your AFT chapter chair, or send through district mail to the AFT 1493 office at CSM (1-255).

Name_____ Street Address_____

Campus_____ City_____ Zip Code_____

Dept/Div_____ Home Ph#_____ Cell Ph#_____

Offi ce Bldg/rm#_____ G#_____

Offi ce Ph#_____ *Check One Below:*

Non-work email_____ Full-Time☐ Part-Time☐

Payroll Deductions for all Faculty

All SMCCCD faculty (both AFT 1493 members and non-members) have a 1.2% payroll deduction from each paycheck's gross earnings. All faculty members are required to sign this authorization for payroll deductions.

Payroll Authorization: Pursuant to Section 87833 of the Education Code and 3543.1 (d) of the Government Code, San Mateo County Community College District is hereby authorized and directed to deduct from each regular salary warrant due for services as an academic employee, the sum necessary to pay union dues (1.2% from each paycheck's gross earnings). The amount so deducted shall be transmitted to AFT 1493 and upon remitting the deduction the District shall have fulfilled its entire obligation and will be held harmless in the event of defalcation on the part of the organization or any of its employees.

Name (please print)_____ Signature_____ Date_____

THIS AUTHORIZATION IS TO REMAIN IN FORCE UNTIL CANCELED OR REVISED BY ME IN WRITING.

All SMCCCD faculty (both AFT 1493 members and non-members) have a 1.2% payroll deduction from each paycheck's gross earnings. All faculty members are required to sign this authorization for payroll deductions.

Signature_____ **Date**_____

AFT 1493, Building 1, Room 255, 1700 W. Hillsdale Blvd., San Mateo, CA, 94402, 650-574-6491

aft1493-aflcio

SAN MATEO COUNTY COMMUNITY COLLEGE DISTRICT

Cañada College • College of San Mateo • Skyline College

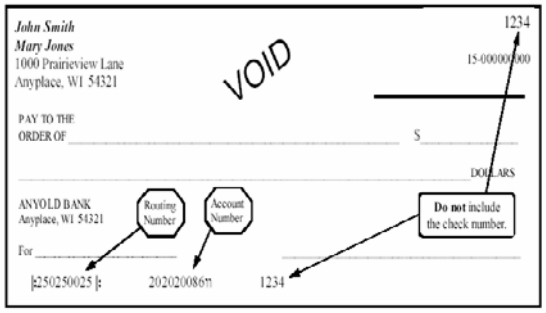
Payroll Office
3401 CSM Drive
San Mateo, CA 94402

PAYROLL DIRECT DEPOSIT AUTHORIZATION FORM

☐ Initial Request ☐ Change ☐ Cancel

Please attach VOID Check here or attach financial institution printout.

- Please read and return this completed form to the Payroll Office.
- **Checking account**: For verification purposes, please attach a voided check to this form. If paper checks are not available, a printout from the financial institution is required in order to process.
- **Savings account**: Contact your financial institution to obtain its transit routing number. A printout from the financial institution is required in order to process.



- Direct deposit goes into effect the following month after the initial request is processed.
- Issue dates (pay dates) for direct deposit are the last working day of the month (the last day that the San Mateo County Community College District Offices are open for business in the month). For student assistants and short term employees, direct deposit issuing dates are the middle of the month (usually the 15th).
- Employee recognizes that there could be a delay in the deposit to his/her account and that Employer is responsible only for transmitting net pay to paying bank designated by County Treasurer. Employer assumes no responsibility beyond that point.
- Employer may remove an employee from direct deposit when payment must be stopped to ensure compliance with legal requirements. Examples are: lack of valid credentials; salary attachments, etc.

NAME ON ACCOUNT	TRANSIT/ABA NUMBER	ACCOUNT NUMBER	ACCOUNT TYPE: Checking/Savings	AMOUNT
				Remaining Net Pay Balance will be deposit to this account.

I hereby authorize San Mateo County Community College District, hereinafter called EMPLOYER, to initiate credit entries and to initiate, if necessary, debit entries and adjustments for any credit entries in error to my indicated account and the depository institution named below, hereinafter called DEPOSITORY, to credit and/or debit the same to such account.

This authorization is to remain in effect until the EMPLOYER has received written notification from me of its termination in such time and in such manner as to afford EMPLOYER and DEPOSITORY a reasonable opportunity to act on it.

I have read and agree to the foregoing.

Employee Name _____ G# _____ Employee Signature _____ Date _____

DISTRIBUTION: ORIGINAL – Employer Payroll Department PHOTOCOPY – Employee

Revised December 2016

SAN MATEO COUNTY COMMUNITY COLLEGE DISTRICT

Cañada College • College of San Mateo • Skyline College

REQUEST FOR VERIFICATION OF PART TIME FACULTY TEACHING EMPLOYMENT

The individual noted below has applied for a certificated, adjunct teaching position at SMCCCD. For purposes of employment verification and/or salary placement, please complete this form and return to:

College of San Mateo: Kathy McEachron
Payroll Technician/Business Services
Building10 Room 447
1700 West Hillsdale Blvd.
San Mateo, CA 94402
Phone: (650) 574-6216
Fax: (650) 574-6162

Cañada College: Christine Huynh
Payroll Technician/Operations Office
Building 18 Room 107
4200 Farm Hill Blvd.
Redwood City, CA 94061
Phone: (650) 306-3207
Fax: (650) 306-3484

Skyline College: Hoi Yin (Amy) Yiu, Payroll Technician/Business Services Building 4 Room 326
3300 College Drive
San Bruno, CA 94066
Phone: (650) 738-4442
Fax: (650) 738-4338

Employee

NEW HIRE: Please complete, sign and forward this form to your prior/current employer for verification.

Name: _____
(Last name) *(First name)* *(Middle initial)*

Maiden/ Former Last Name (if any): _____

Title of Position: _____ Employee G Number: _____

Company Name: _____ Phone: _____

Address: _____
(Street address) *(City)* *(State)* *(Zip code)*

I hereby authorize the release of any information regarding my employment:

Signature: _____ Date: _____

Prior Employer

PRIOR/CURRENT EMPLOYER SECTION:

Job Title: _____ Total Paid Hrs.:_____ Total FTE: _____

Full-Time Employment: From: _____ To: _____ Hours per week: _____
(Month/year) *(Month/year)*

Part-Time Employment: From: _____ To: _____ Sem. Units ☐ Qtr. Units ☐

From: _____ To: _____ Sem. Units ☐ Qtr. Units ☐

From: _____ To: _____ Sem. Units ☐ Qtr. Units ☐

_____ _____
(Please PRINT Name of person verifying employment) *(Title)*

_____ _____
(Signature) *(Date)*

SAN MATEO COUNTY COMMUNITY COLLEGE DISTRICT

Cañada College • College of San Mateo • Skyline College

PROFESSIONAL/VOCATIONAL EXPERIENCE
REQUEST FOR VERIFICATION OF PART TIME FACULTY EMPLOYMENT

The individual noted below has applied for a certificated, adjunct teaching position at SMCCCD. For purposes of employment verification and/or salary placement, please complete this form and return to:

College of San Mateo: Kathy McEachron
Payroll Technician/Business Services
Building 10 Room 447
1700 West Hillsdale Blvd.
San Mateo, CA 94402
Phone: (650) 574-6216
Fax: (650) 574-6162

Cañada College: Christine Huynh
Payroll Technician/Operations Office
Building 18 Room 107
4200 Farm Hill Blvd.
Redwood City, CA 94061
Phone: (650) 306-3207
Fax: (650) 306-3484

Skyline College: Hoi Yin (Amy) Yiu, Payroll Technician/Business Services Building 4 Room 326
3300 College Drive
San Bruno, CA 94066
Phone: (650) 738-4442
Fax: (650) 738-4338

Employee

NEW HIRE: Please complete, sign and forward this form to your prior/current employer for verification.

Name: _____
(Last name) *(First name)* *(Middle initial)*

Maiden/ Former Last Name (if any): _____

Title of Position: _____ Employee G Number: _____

Company Name: _____ Phone: _____

Address: _____
(Street address) *(City)* *(State)* *(Zip code)*

I hereby authorize the release of any information regarding my employment:

Signature: _____ Date: _____

Prior Employer

PRIOR/CURRENT EMPLOYER SECTION:

Job Title: _____

Full-Time Employment: From: _____ To: _____ Hours: _____ FTE: _____
(Month/year) *(Month/year)*

Part-Time Employment: From: _____ To: _____ Hours: _____ FTE: _____
(Month/year) *(Month/year)*

Job Duties:

_____ _____
(Please PRINT Name of person verifying employment) *(Title)*

_____ _____
(Signature) *(Date)*

If self-employed, please complete both sections.

_____
Signature – All information is true and accurate to the best of my knowledge.

SAN MATEO COUNTY COMMUNITY COLLEGE DISTRICT
Cañada College • College of San Mateo • Skyline College

Office of Human Resources
3401 CSM Drive – San Mateo, CA 94403
Automated Service Line: (650) 574-6555
Fax: (650) 574-6574

NEW EMPLOYEE DEMOGRAPHICS

Pursuant to United States Executive Order 11246 and California Legislative Code Title V, the San Mateo County Community College District is required to collect and maintain demographic information for all of its employees. This information is periodically reported to State and Federal compliance agencies and to the State Chancellor's Office of the California Community Colleges. You are not identified by name in any reports submitted by the District.

Per U.S. Department of Education guidelines, colleges are required to collect the following racial and ethnic data.

Are you Hispanic or Latino? ☐ **YES** ☐ **NO**

PART I: RACIAL/ETHNIC GROUP (Check one or more)

- ☐ Mexican, Mexican-American, Chicano
- ☐ Central American
- ☐ South American
- ☐ Hispanic: Other
- ☐ Asian: Indian
- ☐ Asian: Chinese
- ☐ Asian: Japanese
- ☐ Asian: Korean
- ☐ Asian: Laotian
- ☐ Asian: Cambodian
- ☐ Decline to State
- ☐ Asian - Vietnamese
- ☐ Filipino
- ☐ Asian: Other
- ☐ Black or African American
- ☐ American Indian/Alaskan Native
- ☐ Pacific Islander: Guamanian
- ☐ Pacific Islander: Hawaiian
- ☐ Pacific Islander: Samoan
- ☐ Pacific Islander: Other
- ☐ White
- ☐ Unknown

Part II: Gender ☐ Female ☐ Male ☐ Non-Binary **Marital Status** ☐ Single ☐ Married

PART III: VETERAN STATUS

Are you a Veteran? ☐ YES ☐ NO Active Duty Separation Date:_____

Veteran Category: Vietnam Disabled Armed Forces Services Medal Other:_____

PART IV: EMPLOYEE DISABILITY

Pursuant to the Americans with Disabilities Act, the District seeks to provide reasonable accommodations to employees who have disabilities, in order to enable them to perform the essential functions of their positions.

Do you have a disability? ☐ YES ☐ NO

IF YES, what accommodations do you require in order to perform the essential functions of your job?

Please specify:_____

Employee Name	Employee Signature	Date

SAN MATEO COUNTY COMMUNITY COLLEGE DISTRICT

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Automated Service Line: (650) 574-6555
Fax: (650) 574-6574

FINGERPRINTING INFORMATION AND PROCEDURES

Pursuant to the California Education Code, District Rules and Regulations, and applicable laws, employees of the San Mateo County Community College District are required to be fingerprinted. Please complete your fingerprinting prior to your first day of employment.

- All permanent employees (whether full time or part time), adjunct faculty, assistant coaches and volunteers.
- All employees who will be working with money, minors, or health services regardless of the duration of the employment, or whether it is full time or part time)
- All employees, including short term employees and students assistants who will be working for a semester or longer.

Fingerprinting for new District employees can be completed at any of our Bookstore locations:

- **College of San Mateo, Campus Copy & Post, Building 10 Room 190, 1700 W Hillsdale Blvd, San Mateo, CA 94402**
  Q: CSM (650-574-6367) csmbookstore@smccd.edu

- **Skyline College, Graphics Art & Production, Building 5 Room 118, 3300 College Drive, San Bruno, CA 94066**
  Q: Skyline (650-738-4014) skylinebookstore@smccd.edu

- **Cañada College, Bookstore Building 2, 4200 Farm Hill Blvd, Redwood City, CA 94061**
  Q: Cañada (650-306-3313) canadabookstore@smccd.edu

Appointments are made at: http://smccd.edu/livescan/

You are required to bring the following items with you to your fingerprint appointment:

1.) **A non-expired U.S. Driver's License or DMV issued ID Card: Please see alternate identifications**
2.) **A Completed Livescan Request form**

NOTE: International students can wait until they receive their first pay check to be fingerprinted so that they can use their foreign passport and pay stub for identification.

Your fingerprints will be processed in approximately one (1) to three (3) business days, and the results will be reported to the Vice Chancellor, Human Resources and General Counsel.

Previous convictions are reviewed carefully as to type of violation, regency, severity and relevance to the type of work for which you are being hired. Criminal record information is processed in strictest confidence and pursuant to regulations of the State of California Department of Justice, Bureau of Criminal Identification and Information, California Education Code and SMCCCD Rules and Regulations.

No person, who has been convicted of any sex offense as defined by the California Education Code or convicted of a controlled substance offense, shall be employed or retained in employment by a California community college district.

TUBERCULOSIS PROCEDURES

The California Education Code 87408.6 and District Board Policies and Procedures require that all employees and volunteers submit to a TB risk assessment, developed by CDPH and CTCA and if risk factors are present, a blood test, chest x-ray and/or an examination to determine that they are free from infectious TB; This procedure is required initially upon hire, and every four years thereafter while employed by the district. This procedure is at no cost to the employee or volunteer.

Newly hired District employees are required to provide certified proof prior to the start of District employment. Continuing employees must be reassessed for new tuberculosis risk factors every four (4) years.

For your convenience, the TB risk assessment upon hire and every 4 years can be completed by each of the District College Health Centers by appointment only. Please use emails below for scheduling with the respective college you work at or will be working at:

- **Skyline College: TBComplianceSKY@smccd.edu**
- **College of San Mateo: TBComplianceCSM@smccd.edu**
- **Cañada College: TBComplianceCAN@smccd.edu**

Employees with no risk factors will be reassessed every (4) years during their employment in the District (or more often as directed by a local health officer). There will be no TB blood test required during reassessment appointments unless there are new TB risk factors present. Employees who have tested positive for TB upon initial hire and had a negative chest x-ray and/or examination, and were cleared from infectious tuberculosis, require no follow up reassessment during their employment in the District unless tuberculosis symptoms arise, at which point they should schedule an appointment with their primary health care provider. If someone is identified to have latent tuberculosis, this is not treated at the College Health Centers, and these individuals will be referred to an outside healthcare provider for treatment.

Employees with identified tuberculosis risk factors will be sent for a QuantiFERON blood test at a QUEST Diagnostic Laboratory and if the test is positive will be referred by Health Center staff for an X-ray of the lungs within **7 days** of completion of the positive blood test. The health centers may refer employees to Peninsula Ultrasound Medical Group or to another care provider to determine the need for follow-up care.

Employees who are referred for chest X-rays will be reimbursed by the District for out-of-pocket costs incurred for the examination if the medical provider does not bill the District directly.

CERTIFICATION WITHIN THE LAST 60 DAYS
New employees who have received certification within the last 60 days immediately preceding District employment may submit the certificate to their respective college health center for approval. This certificate must be from a licensed medical provider.

INDIVIDUALS WHO TRANSFERRED FROM ANOTHER K-12 SCHOOL OR COLLEGE DISTRICT
New employees transferring from another school or college district may provide proof of freedom from tuberculosis from that previous employer if the examination was completed within the last four (4) years immediately prior to the District employment. This documentation needs to be submitted to their respective district health center using the email addresses above. During the appointment, the nurse will review and verify the record and determine the next steps. The certificate must be from a licensed medical provider and will not be valid if it is over four years since certification.

SPECIAL EXEMPTION
Following termination of a pregnancy, employees may be exempted from the requirement to provide proof of freedom from tuberculosis by chest X-ray for a period not to exceed sixty (60) days. After the 60-day period, contact your respective College Health Center to complete the TB requirement for employment.

STATE OF CALIFORNIA
BCIA 8016
(Rev. 04/2020)

Print Form | Reset Form

REQUEST FOR LIVE SCAN SERVICE

Applicant Submission

A1200
ORI (Code assigned by DOJ)

SCHOOL EMPLOYEE
Authorized Applicant Type

Type of License/Certification/Permit OR Working Title (Maximum 30 characters - if assigned by DOJ, use exact title assigned)

Contributing Agency Information:

SAN MATEO COUNTY COMMUNITY COLLEGE DISTRICT
Agency Authorized to Receive Criminal Record Information

03734
Mail Code (five-digit code assigned by DOJ)

3401 CSM DRIVE
Street Address or P.O. Box

JAY KUMARI - BOOKSTORE OPERATIONS ASSISTANT
Contact Name (mandatory for all school submissions)

SAN MATEO
City

CA
State

94402
ZIP Code

(650) 574-6320
Contact Telephone Number

Applicant Information:

Last Name

First Name | Middle Initial | Suffix
N/A

Other Name: (AKA or Alias)

Last Name

First Name | Suffix
N/A

Date of Birth

Sex ☐ Male ☐ Female

N/A
Driver's License Number

N/A
Height

N/A
Weight

N/A
Eye Color

N/A
Hair Color

Billing Number: 141009
(Agency Billing Number)

N/A
Place of Birth (State or Country)

Social Security Number

Misc. Number: N/A
(Other Identification Number)

Home Address: N/A
Street Address or P.O. Box

N/A
City

N/A
State

N/A
ZIP Code

I have received and read the included Privacy Notice, Privacy Act Statement, and Applicant's Privacy Rights.

Applicant Signature

Date

Your Number: N/A
OCA Number (Agency Identifying Number)

Level of Service: ☒ DOJ ☐ FBI
(If the Level of Service indicates FBI, the fingerprints will be used to check the criminal history record information of the FBI.)

If re-submission, list original ATI number:
(Must provide proof of rejection)
Original ATI Number

Employer (Additional response for agencies specified by statute):

N/A
Employer Name

N/A
Street Address or P.O. Box

N/A
Telephone Number (optional)

N/A
City

N/A
State

N/A
ZIP Code

N/A
Mail Code (five digit code assigned by DOJ)

Live Scan Transaction Completed By:

Name of Operator

Date

Transmitting Agency

LSID

ATI Number

Amount Collected/Billed

REQUEST FOR LIVE SCAN SERVICE

Privacy Notice

As Required by Civil Code § 1798.17

Collection and Use of Personal Information. The California Justice Information Services (CJIS) Division in the Department of Justice (DOJ) collects the information requested on this form as authorized by Business and Professions Code sections 4600-4621, 7574-7574.16, 26050-26059, 11340-11346, and 22440-22449; Penal Code sections 11100-11112, and 11077.1; Health and Safety Code sections 1522, 1416.20-1416.50, 1569.10-1569.24, 1596.80-1596.879, 1725-1742, and 18050-18055; Family Code sections 8700-87200, 8800-8823, and 8900-8925; Financial Code sections 1300-1301, 22100-22112, 17200-17215, and 28122-28124; Education Code sections 44330-44355; Welfare and Institutions Code sections 9710-9719.5, 14043-14045, 4684-4689.8, and 16500-16523.1; and other various state statutes and regulations. The CJIS Division uses this information to process requests of authorized entities that want to obtain information as to the existence and content of a record of state or federal convictions to help determine suitability for employment, or volunteer work with children, elderly, or disabled; or for adoption or purposes of a license, certification, or permit. In addition, any personal information collected by state agencies is subject to the limitations in the Information Practices Act and state policy. The DOJ's general privacy policy is available at **http://oag.ca.gov/privacy-policy**.

Providing Personal Information. All the personal information requested in the form must be provided. Failure to provide all the necessary information will result in delays and/or the rejection of your request.

Access to Your Information. You may review the records maintained by the CJIS Division in the DOJ that contain your personal information, as permitted by the Information Practices Act. See below for contact information.

Possible Disclosure of Personal Information. In order to process applications pertaining to Live Scan service to help determine the suitability of a person applying for a license, employment, or a volunteer position working with children, the elderly, or the disabled, we may need to share the information you give us with authorized applicant agencies.

The information you provide may also be disclosed in the following circumstances:

- With other persons or agencies where necessary to perform their legal duties, and their use of your information is compatible and complies with state law, such as for investigations or for licensing, certification, or regulatory purposes.
- To another government agency as required by state or federal law.

Contact Information. For questions about this notice or access to your records, you may contact the Associate Governmental Program Analyst at the DOJ's Keeper of Records at (916) 210-3310, by email at **keeperofrecords@doj.ca.gov,** or by mail at:

Department of Justice
Bureau of Criminal Information & Analysis
Keeper of Records
P.O. Box 903417
Sacramento, CA 94203-4170

REQUEST FOR LIVE SCAN SERVICE

Privacy Act Statement

Authority. The FBI's acquisition, preservation, and exchange of fingerprints and associated information is generally authorized under 28 U.S.C. 534. Depending on the nature of your application, supplemental authorities include Federal statutes, State statutes pursuant to Pub. L. 92-544, Presidential Executive Orders, and federal regulations. Providing your fingerprints and associated information is voluntary; however, failure to do so may affect completion or approval of your application.

Principal Purpose. Certain determinations, such as employment, licensing, and security clearances, may be predicated on fingerprint-based background checks. Your fingerprints and associated information/biometrics may be provided to the employing, investigating, or otherwise responsible agency, and/or the FBI for the purpose of comparing your fingerprints to other fingerprints in the FBI's Next Generation Identification (NGI) system or its successor systems (including civil, criminal, and latent fingerprint repositories) or other available records of the employing, investigating, or otherwise responsible agency. The FBI may retain your fingerprints and associated information/biometrics in NGI after the completion of this application and, while retained, your fingerprints may continue to be compared against other fingerprints submitted to or retained by NGI.

Routine Uses. During the processing of this application and for as long thereafter as your fingerprints and associated information/biometrics are retained in NGI, your information may be disclosed pursuant to your consent, and may be disclosed without your consent as permitted by the Privacy Act of 1974 and all applicable Routine Uses as may be published at any time in the Federal Register, including the Routine Uses for the NGI system and the FBI's Blanket Routine Uses. Routine uses include, but are not limited to, disclosures to: employing, governmental, or authorized non-governmental agencies responsible for employment, contracting, licensing, security clearances, and other suitability determinations; local, state, tribal, or federal law enforcement agencies; criminal justice agencies; and agencies responsible for national security or public safety.

REQUEST FOR LIVE SCAN SERVICE

Noncriminal Justice Applicant's Privacy Rights

As an applicant who is the subject of a national fingerprint-based criminal history record check for a noncriminal justice purpose (such as an application for employment or a license, an immigration or naturalization matter, security clearance, or adoption), you have certain rights which are discussed below.

- You must be provided written notification[1] that your fingerprints will be used to check the criminal history records of the FBI.
- You must be provided, and acknowledge receipt of, an adequate Privacy Act Statement when you submit your fingerprints and associated personal information. This Privacy Act Statement should explain the authority for collecting your information and how your information will be used, retained, and shared. [2]
- If you have a criminal history record, the officials making a determination of your suitability for the employment, license, or other benefit must provide you the opportunity to complete or challenge the accuracy of the information in the record.
- The officials must advise you that the procedures for obtaining a change, correction, or update of your criminal history record are set forth at Title 28, Code of Federal Regulations (CFR), Section 16.34.
- If you have a criminal history record, you should be afforded a reasonable amount of time to correct or complete the record (or decline to do so) before the officials deny you the employment, license, or other benefit based on information in the criminal history record. [3]

You have the right to expect that officials receiving the results of the criminal history record check will use it only for authorized purposes and will not retain or disseminate it in violation of federal statute, regulation or executive order, or rule, procedure or standard established by the National Crime Prevention and Privacy Compact Council. [4]

If agency policy permits, the officials may provide you with a copy of your FBI criminal history record for review and possible challenge. If agency policy does not permit it to provide you a copy of the record, you may obtain a copy of the record by submitting fingerprints and a fee to the FBI. Information regarding this process may be obtained at https://www.fbi.gov/services/cjis/identity-history-summary-checks.

If you decide to challenge the accuracy or completeness of your FBI criminal history record, you should send your challenge to the agency that contributed the questioned information to the FBI. Alternatively, you may send your challenge directly to the FBI. The FBI will then forward your challenge to the agency that contributed the questioned information and request the agency to verify or correct the challenged entry. Upon receipt of an official communication from that agency, the FBI will make any necessary changes/corrections to your record in accordance with the information supplied by that agency. (See 28 CFR 16.30 through 16.34.) *You can find additional information on the FBI website at* https://www.fbi.gov/about-us/cjis/background-checks*.*

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[1] Written notification includes electronic notification, but excludes oral notification
[2] https://www.fbi.gov/services/cjis/compact-council/privacy-act-statement
[3] See 28 CFR 50.12(b)
[4] See U.S.C. 552a(b); 28 U.S.C. 534(b); 34 U.S.C. § 40316 (formerly cited as 42 U.S.C. § 14616), Article IV(c)

SAN MATEO COUNTY COMMUNITY COLLEGE DISTRICT
Cañada College • College of San Mateo • Skyline College

Office of Human Resources
3401 CSM Drive, San Mateo, CA 94402
Automated Service Line: (650) 574-6555
Fax: (650) 574-6574

EMERGENCY CONTACT: In case of an emergency, please notify:

_____
Employee Name

#1 Contact Name	_____	#2 Contact Name	_____
Relationship to Employee	_____	Relationship to Employee	_____
Contact Phone	_____	Contact Phone	_____
Home Address	_____	Home Address	_____
City, State, Zip	_____	City, State, Zip	_____
E-mail	_____	E-mail	_____

You may update/add your emergency contact/home telephone/address through websmart any time throughout your employment.

I understand that it is my responsibility to update the information included in this form.

_____ _____
Employee Signature Date

LOYALTY OATH

The Loyalty Oath or Affirmation of Allegiance to the government of the United States of America and to the State of California, is required by the provisions of Article XX, Section 3 of the Constitution of the State of California.

In the State of California, County of San Mateo: I, _____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 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.

Witness my hand this ____ Day of ____ in the Year _____.

_____
Employee Signature

AUTHORIZED DISTRICT REPRESENTATIVE SIGNATURE

Subscribed and sworn to before me this ____ Day of ____ in the year _____.

_____ _____
Supervisor Name Supervisor Signature

Revised September 2017

SAN MATEO COUNTY COMMUNITY COLLEGE DISTRICT
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CONVICTION INFORMATION

_____
Employee Name

Have you ever been convicted, pled guilty to or pled no contest to any criminal offense by any court? ☐ YES ☐ NO

Having a criminal record does not necessarily disqualify you for employment. Each case is given individual consideration, based on job-related criteria.

If yes, please note the date and place of each offense, the specified charge, the date and place of convictions, or plea, the fine or sentence received of the diversion program entered. You may omit any offense for which the only punishment imposed was a fine of less than $100. Any offense for which you were convicted for which the punishment was a fine in excess of $100, which required serving a jail of prison sentence, or which required probation MUST be reported.

All the information provided in this form is true and accurate to the best of my knowledge. I understand that falsification of any part(s) of this application shall be sufficient cause for my disqualification from the selection process or termination from District employment.

_____ _____
Employee Signature Date

W-2 ELECTRONIC FORM CONSENT

To consent to receive your W-2 form electronically, go to WebSMART (http://websmart.smccd.edu). Once you are on WebSMART, select the employee menu tab, then the tax forms link, then the tax consent link and check the box to accept electronic consent. You also have the option to complete this form and submit to the Campus Payroll Office.

By consenting to receive your W-2 form electronically, you agree to go to WebSMART between January 31 and October 15 of the appropriate year to print your W-2 form online. You may be required to print and attach your W-2 form to your Federal, State, or local income tax return.

Your consent will be valid for all subsequent tax years unless revoked by you, upon your termination of District service, or the termination of this service in a future given tax year.

You may revoke your consent at any time and receive a paper form W-2 by accessing WebSMART and un-checking the box. You can also complete this form and submit to the Campus Payroll Office.

A paper copy of your W-2 form may be obtained by contacting the Campus Payroll Office. Updating of employee contact information is the responsibility of the employee by providing correct up-to-date information to the Office of Human Resources or Payroll Office.

Selection Criteria: ◯ Consent to receive W-2 form electronically ◯ Cancel consent to receive W-2 form electronically

I understand the instructions provided to me for accessing and printing my electronic W-2 form.

_____ _____
Employee Signature Date

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Fax: (650) 574-6574

NOTICE AND ACKNOWLEDGMENT OF MANDATED REPORTING PURSUANT TO THE CALIFORNIA CHILD ABUSE/NEGLECT AND ELDER/DEPENDENT ADULT ABUSE/NEGLECT

California Law requires certain persons to report known or suspected child abuse/neglect or known or suspected dependent adult abuse/neglect. These individuals are known under the law as "mandated reporters". As an employee of the San Mateo County Community College District, you are a mandated reporter. You are required to comply with the provision of Welfare and Institutions Code section 15630 in connection with reporting the suspected abuse/neglect of elders/dependent (individual 65 or older) adults. You are required to comply with California penal code, Chapter 2.5 section 11164-11174.3 in connection with reporting the suspected abuse/neglect of a child (anyone under the age of 18).

What to Report:

Any incident that reasonably appears to be physical abuse (including sexual abuse), abandonment, abduction, isolation, financial abuse, or neglect (including self-neglect) of an *elder or dependent adult*.

For Child Abuse/Neglect: 1.) Physical abuse, 2.) Sexual abuse, 3.) Child exploitation, Child pornography, and Child prostitution, 4.) Severe or general neglect, 5.) Extreme corporal punishment resulting in injury, 6.) Willful cruelty or unjustifiable punishment, 7.) Abuse or neglect in out-of-home care.

When to Report:

If you have observed, suspect, or have knowledge of elder/dependent adult abuse/neglect, you must make a report by telephone immediately, or as soon as practically possible, and by written report sent within two working days to the agency.

A telephone report must be made immediately when you, in your professional capacity or within the scope of your employment, observe a child and have knowledge of, or have reasonable suspicion that the child has been abused. A written report, on a standard form, must be sent within 36 hours after the telephone report has been made for child abuse/neglect.

To Whom Do You Report:

For Elder/Dependent Adult Abuse/Neglect: San Mateo County Adult Protective Services at (800) 675-8437.

For Child Abuse/Neglect: Local Police or County Sheriff or Child Protective Services (650) 802-7922 / (800) 632-4615.

Individual Responsibility:

Any individual who is mandated reporter must report abuse. If you confer with another person and a decision is made that other person will file the report, one report is sufficient. However, if the other person does not make the report, you are liable and must make the report.

Confidentiality:

Mandated reporters are required to give their names. Child Protective Agencies are required to keep the mandated reporter's name confidential, unless court orders the information disclosed.

Criminal and Civil Liability:

You can be criminally liable for failing to report suspected abuse or neglect. The penalty for this misdemeanor is up to six months in county jail, a fine of not more than $1,000 or both. You can also be civilly liable for failure to report.

Immunity:

Any legally mandated reporter has immunity when making a report. In the event a civil suit is filed against the reporter, the state will reimburse attorney's fees incurred in the suit up to $50,000 for child abuse/neglect. No individual can be dismissed, disciplined, or harassed for making a report of a suspected child abuse or neglect.

ACKNOWLEDGMENT OF MANDATED REPORTING OF CHILD ABUSE/NEGLECT AND ELDER/DEPEDENT ADULT ABUSE/NEGLECT

I understand that while I am employed by the San Mateo County Community College District, I am a mandated reporter under the Child Abuse and Neglect Reporting Act under California penal code, Chapter 2.5 section 11164-11174.3 and the Elder and Dependent Adult Abuse Neglect under Welfare and Institutions Code Section 15630. A copy of these regulations may be obtain by request. As a mandated reporter, I understand that I have a legal obligation to report child abuse/neglect or elder/dependent adult abuse/neglect and will comply with the laws.

_____	_____	_____
Employee Name	Employee Signature	Date

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3401 CSM Drive – San Mateo, CA 94402
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Fax: (650) 574-6574

workers' Compensation: Pre-Designation of Personal Physician

You have the right to be treated immediately by your personal physician if you notify SMCCCD, in writing, prior to the injury. Per Labor Code 4600 to qualify as your predesignated, personal physician(M.D./D.O), the physician must agree to treat you for a work related injury, must have previously directed your medical care, and must retain your medical history and records.

Please use this form to notify SMCCCD to designate your personal physician. Otherwise, you will be treated by one of our designated workers' compensation panel facilities (listing in our new hire injury/illness reporting packet).

EMPLOYEE NAME: _____

☐ **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 SMCCCD designated workers' compensation panel facilities. 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.** This physician is my personal physician who has previously directed my medical care and retains my medical history and records.
Name of Physician: _____ Phone Number: _____
Physician's Address: _____
Name of Personal health insurance plan coverage: (non-occupational injuries or illnesses)

_____

Employee Signature: _____ Date: _____

A *Personal Physician* must be willing to be a designated physician and treat you for a workers' compensation injury/illness.
The remainder of this form is to be completed by your physician and returned to SMCCCD.

PERSONAL PHYSICIAN ACKNOWLEDGEMENT

Per Labor Code 4600 to qualify **you must agree to be designated as the employee's personal physician and treat this employee for a work related injury**. You must have previously directed the employees medical care and retain their medical history and records. Our primary goal is to provide our employees with prompt, effective, quality medical treatment in the event of an industrial injury. We request your partnership by completing this acknowledgement form.

Personal Physician Name: _____

☐ **I agree to treat the above named employee in the event of an industrial accident or injury**. I have previously directed the employee's medical treatment and retain medical records and medical history. I agree to adhere to the Administrative Director's Rules and Regulations, Section 9785, regarding the duties of the employee-designated physician.

☐ **I do not agree to treat the above employee in the event of an industrial accident or injury.**

☐ **I do not qualify as the employees' personal physician** per Labor Code 4600. I have not previously directed the employee's medical treatment and do not retain medical records and medical history.

Physician Signature: _____ Date: _____

Return Completed Form to: Fax (650) 574-6574, Human Resources, SMCCCD, 3401 CSM Drive, San Mateo, CA 94402

SAN MATEO COUNTY COMMUNITY COLLEGE DISTRICT

Cañada College • College of San Mateo • Skyline College

NEW HIRE
WORKERS' COMPENSATION NOTICE

WORKERS' COMPENSATON COVERAGE

You may be entitled to workers' compensation benefits if you are injured or become ill due to your employment with SMCCCD. Workers' compensation covers most work-related physical or mental injuries and illnesses. An injury or illness can be caused by one event (such as hurting your back in a fall) or by repeated exposures such as hurting your wrist from doing the same motion over and over).

BENEFITS

Workers' compensation benefits include: Medical care, temporary disability, permanent disability, supplemental job displacement voucher, and death benefits.

MEDICAL CARE

You are entitled to medical care that is reasonably required to cure or relieve you from the effects of your work-related injury. Medical care may include doctor visits, hospital services, physical therapy, lab tests, x-rays, and medicines that are reasonably necessary to treat your injury. Providers should never bill you directly for work-related injuries. There is a limit on some medical services.

SMCCCD is required to provide you with a claim form within one (1) business day of learning about your injury. It is extremely important that you complete the "Employee" section of the claim form as SMCCCD is required to authorize medical care within one (1) working day after you file the form. If additional care is necessary after the initial treatment, Sedgwick CMS may authorize care that is appropriate for your injury, including the referral to a specialist.

SMCCCD has designated facilities near the work premises to treat injuries/illnesses that occur out of your employment with SMCCCD where medical treatment is provided.

YOUR PRIMARY TREATING PHYSICIAN (PTP)

This is the physician with the overall responsibility for treating your injury or illness. The primary treating physician determines what type of treatment you need and when you may return to work. A multispecialty medical group of licensed doctors and osteopathy can be designated as personal physicians. You may request to change your treating physician to your personal chiropractor or acupuncturist following a work- related injury or illness to Sedgwick CMS. If specialists, diagnostics, etc. are needed in your case, this physician will be responsible for making the referrals. If you name your personal physician before your injury, you may be treated by him or her for work related injuries/illnesses. Otherwise, SMCCCD has the right to select the physician who will treat you for the first 30 days. You may be able to switch to a physician of your choice after 30 days.

YOUR PERSONAL PHYSICIAN CARE

You may be treated by your personal physician if you notify SMCCCD prior to your injury. A personal physician includes a medical group of licensed doctors of medicine or osteopathy. Please have your physician complete a pre-designate personal physician form available at our District Portal website: http://smccd.edu/portal. The following requirements must be met:

1. Your personal physician must agree in advance to treat you for any work injuries or illnesses.
2. Your personal physician must be your regular physician (general/family practitioner, board certified internist, board certified pediatrician, board certified obstetrician/gynecologist.
3. Your physician has previously directed your medical treatment and retains your records, including your medical history.

EMERGENCY MEDICAL CARE

If you need emergency care, call 911 immediately for the hospital, ambulance, fire department or police department. You may also contact our college nurse or our campus college safety department.

FIRST AID

If you need first aid treatment, contact your college nurse or Human Resources.

An incident report form needs to be completed by the employee and supervisor for an acknowledgment that an incident has occurred where no medical care beyond first aid is needed and no loss time has occurred.

REPORT YOUR INJURY

Report a work related injury or illness immediately to your supervisor/administrator or Human Resources at (650) 358-6724. You may download the new hire injury/illness reporting packet from our District portal website.

Don't delay. There are time limits. If you wait too long, you may lose your right to benefits. SMCCCD is required to provide you with a claim form within one working day after learning about your injury. Until the date the claim is accepted or rejected, liability for medical treatment shall be limited to ten thousand dollars ($ 10,000) within one working day after you file a claim form. If your claim is denied, you have the right to appeal the decision within one year of the date of injury.

TEMPORARY DISABILITY BENEFITS (TD)

You may be entitled to payments if you lose wages while recovering. Your temporary disability rate is calculated by multiplying your average weekly wage by two thirds. The first 3 days of disability are not payable under California law unless there is hospitalization at the time of injury or the disability exceeds 14 days. If your physician returns you to work on a modified basis, you may be entitled to wage loss. This is generally calculated by multiplying the difference between your average weekly wage and your earnings during modified duties times two thirds. This is subject to the benefit minimums and maximums set by the California Legislature. Temporary disability benefits are payable within 14 days of the date of injury or knowledge of the injury. Subsequent payments are due every 14 days. For injuries occurring on or after 1/1/08, no more than 104 weeks of temporary disability are payable within 5 years from the date of injury. For longer term conditions (hepatitis B &C, amputations, severe burns, HIV, high velocity eye injuries, chemical burns to the eyes, pulmonary fibrosis, and chronic lung disease) no more than 240 weeks within five years from the date of injury are payable. You may be eligible for state disability benefits from the Employment Development Department (EDD) if TD benefits are stopped, delayed, or denied. There are time limits so contact EDD for more

information. This is applicable if you currently pay for state disability insurance through another employer.

PERMANENT DISABILITY BENEFITS (PD)

You may be entitled to payments if your physician says your injury has limited your ability to work. The permanent disability rate is calculated by multiplying your average weekly wage by two thirds, subject to statutory minimums and maximums. The amount of permanent disability or impairment may depend on your doctor's opinion, as well as your age, occupation type of injury and date of injury. If you have permanent disability or your claims examiner suspects you have permanent disability, a letter will be sent to you explaining your benefits, including the estimate or total value of permanent disability, weekly payment amount, how the benefit was calculated, and all of your related rights under the California Labor Code, including your right to object to the report upon which the determination is being based. Permanent Disability benefits are payable within 14 days of the last payment of temporary disability benefits or after your physician indicates there is permanent disability. The benefit is payable every fourteen days. Permanent Disability Benefits are not payable until your claim is finalized if the District offers a job upon termination of temporary disability benefits.

SUPPLEMENTAL JOB DISPLACEMENT BENEFITS

You may be entitled to a nontransferable voucher payable to a state approved school. To qualify, your injury must result in a permanent impairment and the District is unable to offer modified or alternative work within 60 days of receipt of a report asserting that all medical conditions have reached maximum medical improvement. If the District does not offer a modified or alternative job within 60 days of termination of maximum medical improvement, you may choose to receive a non-transferable voucher to use at a state accredited school for education related retraining or skill replacement benefit, you claims examiner will provide a voucher for up to $6,000.

RETURN TO WORK FUND

If your injury results in permanent impairment and it is determined that the amount awarded is disproportionately low in comparison to your loss of earnings, you may be entitled to additional compensation. A fund was established to supplement permanent impairment benefits under specific circumstances. This fund is administered by the Division of Workers Compensation. Your examiner can assist in directly in to the correct resource to determine eligibility.

DEATH BENEFITS

Death benefits are paid to dependents of a worker who dies from a work-related injury or illness. The benefit is calculated and paid in the same manner as temporary disability. This benefit is paid at a minimum rate of $224 per week. The death benefit rates are set by state law and the amount depends upon the number of dependents. If dependent minor children are involved, death benefits are payable at least until the youngest child reaches majority age. Burial expenses are also provided under this benefit.

AVAILABLE FORMS

Forms are available through our District Portal Web Site at: http://www.smccd.edu/portal click downloads, human resources folder, worker's compensation folder. You will find our designated facility panel listing for medical care. You will also find the pre-designated personal physician form to designate prior to your injury/illness at any time throughout your employment with SMCCCD. You may also find the worker's compensation new injury reporting packet. The packet provides forms to be completed by the injurer, your supervisor and information sheets related to benefits that you may be eligible.
For District Vehicle accidents Reporting, please complete additional forms.
Please visit Frequent Asked Questions regarding Worker's Compensation.

CLAIMS ADMINISTRATOR

Sedgwick Claims Management Services, MCU WC

P.O. Box 14479, Lexington, KY 40512-4479

Telephone: (877) 809-9478

You may contact an information and assistance officer at the State Division of Workers' Compensation, toll free (800) 736-7401, visit http://www.dir.ca.gov, San Francisco Office (415) 703-5020 San Jose Office (408) 277-1292.

EMPLOYER DISPUTES YOUR INJURY

State law requires SMCCCD to authorize medical care within one working day of receiving a DWC 1 claim form. Your employer may be liable for as much as $10,000 in medical care until your claim is accepted or denied.

QUESTIONS

If you have questions, you may contact Human Resources at (650) 358-6724.

You may consult an attorney. Most attorneys offer one free consultation. If you decide to hire an attorney, his or her fee will be taken out of some of your benefits. For names of workers' compensation attorneys, call the State Bar of California at (415) 538-2120.

DISCRIMINATION

It is illegal for SMCCCD to punish or fire you for having a work injury or illness, for filing a claim, or testifying in another person's workers' compensation case. If proven, you may receive lost wages, job reinstatement, increased benefits, and costs and expenses up to limits set by the state.

FALSE CLAIMS AND FALSE DENIALS

Any person who makes or causes to be made any knowingly false or fraudulent material statement or material representation for the purpose of obtaining or denying workers' compensation benefits or payments is guilty of a felony and may be fined and imprisoned. (Insurance Code 1871.4)

SMCCCD may not be liable for the payment of workers' compensation benefits for any injury/illness that arises from your voluntary participation in any off-duty recreational, social, or athletic activity that is not part of your work-related duties.

Revised Jan 2017

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Office of Human Resources
3401 CSM Drive – San Mateo, CA 94402
Automated Service Line: (650) 574-6555
Fax: (650) 574-6574

RIGHTS OF VICTIMS OF DOMESTIC VIOLENCE, SEXUAL ASSAULT AND STALKING

Your Right to Take Time Off:

- You have the right to take time off from work to get help to protect you and your children's health, safety or welfare. You can take time off to get a restraining order or other court order.
- If your company has 25 or more workers, you can take time off from work to get medical attention or services from a domestic violence shelter, program or rape crisis center, psychological counseling, or receive safety planning related to domestic violence, sexual assault, or stalking.
- You may use available vacation, personal leave, accrued paid sick leave or compensatory time off for your leave unless you are covered by a union agreement that says something different. Even if you don't have paid leave, you still have the right to time off.
- In general, you don't have to give your employer proof to use leave for these reasons.
- If you can, you should tell your employer before you take time off. Even if you cannot tell your employer before, your employer cannot discipline you if you give proof explaining the reason for your absence within a reasonable time. Proof can be a police report, court order or doctor's or counselor's note or similar document.

Your Right to Reasonable Accommodation:

- You have the right to ask your employer for help or changes in your workplace to make sure you are safe at work. Your employer must work with you to see what changes can be made. Changes in the workplace may include putting in locks, changing your shift or phone number, transferring or reassigning you, or help with keeping a record of what happened to you. Your employer can ask you for a signed statement certifying that your request is for a proper purpose, and may also request proof showing your need for an accommodation. Your employer cannot tell your coworkers or anyone else about your request.

Your Right to Be Free from Retaliation and Discrimination:

Your employer cannot treat you differently or fire you because:

- You are a victim of domestic violence, sexual assault, or stalking.
- You asked for leave time to get help.
- You asked your employer for help or changes in the workplace to make sure you are safe at work.

You can file a complaint with the Labor Commissioner's Office against your employer if he/she retaliates or discriminates against you.

For more information, contact the California Labor Commissioner's Office. We can help you by phone at 213-897-6595, or you can find a local office on our website: www.dir.ca.gov/dlse/DistrictOffices.htm. This Notice explains rights contained in California Labor Code sections 230 and 230.1.

Please contact Human Resources for further information.

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WELCOME TO OUR DISTRICT

The Human Resources Department is an excellent resource for information that you need related to your personnel file, health benefits, salary placement, employment verifications, training opportunities, promotional opportunities, paid and unpaid leaves, retirement system procedures and many other employee services. You may also find policies, procedures, and rights that you will utilize during your career in our District! Please visit our New Employee Orientation website: http://smccd.edu/orientation.

You may also visit Websmart at: https://websmart.smccd.edu/ where you have employee services such as reporting your accrued sick/vacation/comp time used each month and balances, benefits and payroll deductions, pay information, change your income tax allocation, update your emergency contact and change your mailing address. We also recommend that you sign up for AlertU- Emergency Text Message Notification.

Please visit our District Portal Website: http://smccd.edu/portal under Downloads Tab, where you will find employment forms available for Human Resources and other departments. You will be able to create a work order for Facilities Department and Information Technology Services as well.

Julie Johnson, Chief Human Resources Officer
Telephone Number: (650) 358-6883 (extension 6883) Email Address: johnsonjulie@smccd.edu
Department administrator; Employee and labor relations; HR representative to the Board of Trustees; District/HR policies and procedures administration; Human Resources advice and counsel.

David Feune, Director of Human Resources Telephone Number: (650) 358-6775 (ext. 6775) E-mail Address: feune@smccd.edu Position control; selection procedures; employee and labor relations; new faculty salary placement; Equal Employment Opportunity; job descriptions; administrative selection committee orientations; collective bargaining agreements negotiation and information; board reports; faculty diversity internship; Professional development academy.	**Noemi Diaz, Compensation and Benefits Manager** Telephone Number: (650) 358-6844 E-mail Address: diazn@smccd.edu 403(b) and 457 retirement plans; vendor contract renewals; reporting; salary schedules; exit interviews; retirement information; retiree benefits and payments; employee compensation/job assignments.
Ingrid Melgoza, Senior Human Resources Representative Telephone Number: (650) 358-6724 (ext. 6724) E-mail Address: melgozai@smccd.edu Leave of absence process; workers' compensation; ADA; return to work; training module administrator; downloads update; ergonomic evaluations; on-line coordinate training sessions.	**Mwanaisha Sims, Director of Policy, Training, & Compliance** Telephone Number : (650) 358-6808 (ext. 6808) E-mail Address: simsm@smccd.edu Conduct training sessions for District faculty, staff and students on District policy and procedures; ensuring District compliance on policies and procedures consistent with federal and state law regulations; conduct internal investigations; MOT coordinator.
Jennie Elizalde, Senior Human Resources Representative Telephone Number: (650) 358-6822 (extension 6822) E-mail Address: elizaldej@smccd.edu Job postings; recruitment; online employment site specialist; classified selection committee orientations and resource; selection procedures; applicant tracking administrator, ergonomic evaluations.	**Jim Vlahos, Senior Human Resources Representative** Telephone Number: (650) 358-6804 (ext. 6804) Email Address: vlahosjames@smccd.edu Track and create salary orders, step increases, long service increment and compensation time; manage sick/vacation leave accrual; classification reviews, ergonomic evaluations.
Teddy Washington, Human Resources Representative Telephone: (650) 358-6723 (ext. 6723) E-mail Address: washingtont@smccd.edu Applicant services, including Online employment site assistance; verifications of employment; name changes; fingerprinting appointments; unemployment claims; performance evaluation/ tuberculosis tracking; employment records; faculty contract tracking.	**Jessica Esclamado-David, Human Resources Representative** Telephone Number : (650) 358-6827 (ext. 6827) E-mail Address: esclamadodavidj@smccd.edu Health benefits info for medical, dental, vision and life insurance; employee assistance program; flexible spending accounts; short-term employment; new employment preparation; DMV pull; wellness program.
Jasmeet (Jazz) Singh, Human Resources Representative Telephone Number: (650) 358-6779 (ext. 6779) E-mail Address: singhj@smccd.edu Classified & faculty selection committees; selection procedures; job postings; applicant services; new employment preparation; new hire orientation; student assistant employment.	**George Sampior, Human Resources Representative** Telephone Number: (650) 358-6744 (ext. 6744) E-mail Address: sampiorg@smccd.edu Health Benefit billings; track COBRA payment and info; retiree medical benefits and payments; adjunct faculty medical reimbursement program.