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

NEW FACULTY WELCOME PACKET

INTERNAL USE

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

Name: _____ G#: _____ DOH: _____
Dept/Div: _____ Job Title: _____ Position #: _____
Grade: _____ Step: _____ Percent of Full Time _____ Months/Year: _____

- ☐ Personnel Action Form
- ☐ Application and Resume
- ☐ Job Announcement
- ☐ Job Offer Letter
- ☐ Emergency Contact information
- ☐ New Hire Workers Compensation Notice
- ☐ WC: Pre-designated Personal Physician Form
- ☐ I-9 Employment Eligibility Verification
- ☐ Copy of Social Security Card
- ☐ Copy of I-9 documentation
- ☐ Child Abuse Reporting Policy
- ☐ Elder/Dependent Adult Abuse Reporting Policy
- ☐ Loyalty Oath Policy
- ☐ New Employee Demographics
- ☐ W-4 Employee Withholding Allowance
- ☐ Electronic W-2 consent Form/ 1095 Form
- ☐ Payroll Direct Deposit Form
- ☐ Payroll Option Form
- ☐ AFT Union Membership Application
- ☐ ACH Authorization Agreement

- ☐ Retirement System Membership
- ☐ CALPERS Reciprocal Self-Certification Form
- ☐ CALSTRS Retirement System Election Form
- ☐ CALSTRS Acknowledgment Form
- ☐ SSA-1945 Job not covered by Social Security
- ☐ Hire-Right Background Check and Submission
- ☐ Proof of Tuberculosis
- ☐ Fingerprinting Completed

Notes:

BANNER ENTRY CHECKLIST

☐ PPAIDEN ☐ Biographic ☐ Address ☐ Emergency	☐ PEAEMPL ☐ NBAJOBS	☐ PDABDSU ☐ BENEFIT FORMS	☐ PEAREVW ☐ Fingerprinting ☐ Tuberculosis ☐ Perfor Eval ☐ I-9 Tracking	☐ GOATPAC ☐ PEABARG	☐ PPACMNT Pay schedule ☐ PPACMNT ☐ PPAGENL ☐ PPACERT

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Fax: (650) 574-6574

CONTACT INFORMATION FORM

First and Last Name		Cell Phone #	
Home Address		Landline #	
State		City	
Email Address		Zip Code	

If your mailing address is different from your home address, please complete the information below:

Mailing Address		City	
State		Zip Code	

In case of an emergency, please notify:
(Please Complete by Order of Contact / Minimum of Two Emergency Contacts is Preferred.)

#1 Emergency Contact		#2 Emergency Contact	
First and Last Name		First and Last Name	
Relationship to Employee		Relationship to Employee	
Home Address		Home Address	
City		City	
State		State	
Zip Code		Zip Code	
Cell Phone #		Cell Phone #	
Landline #		Landline #	
Email		Email	

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

Employee Signature: _____ Date: _____

Note: You may update your emergency contact and your address through Websmart at any time throughout your employment.

SAN MATEO COUNTY COMMUNITY COLLEGE DISTRICT
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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 March 2019

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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
Revised March 2019

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NOTICE AND ACKNOWLEDGMENT OF MANDATED REPORTING PURSUANT TO THE CALIFORNIA CHILD ABUSE AND NEGLECT REPORTING LAW

California law requires certain persons to report known or suspected child abuse or 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 and are required by law to report the suspected abuse or neglect of a child (anyone under the age of 18).

What to Report:

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:

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.

To Whom Do You Report:

You have a choice of reporting to the local police or the County Sheriff or Child Protective Services (650-802-7922 or 800-632-4615).

Individual Responsibility:

Any individual who is a 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 the 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. No individual can be dismissed, disciplined or harassed for making a report of suspected child abuse.

If you have any questions about the information above, please contact the Office of Human Resources.

ACKNOWLEDGMENT OF MANDATED REPORTING OF CHILD ABUSE

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 (California Penal Code, Chapter 2.5, Section 11166). A copy of Penal Code Sections 11165.7, 11166, and 11167 is available upon request. As a mandated, I understand that I have a legal obligation to report child abuse and negligence and will comply with the law.

_____	_____	_____
Employee Name	Employee Signature	Date

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NOTICE AND ACKNOWLEDGEMENT OF MANDATED REPORTING OF SUSPECTED ELDER OR DEPENDENT ADULT ABUSE

California law requires certain persons to report known or suspected elder or dependent adult abuse. 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 and are required to comply with the provisions of Welfare and Institutions Code Section 15630 in connection with reporting the suspected abuse of elders (individuals 65 or older) and dependent adults.

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.

When to Report:
If you have observed, suspect, or have knowledge of abuse, 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.

To Whom Do You Report:
San Mateo County Adult Protective Services at 1-800-675-8437

Individual Responsibility: Any individual who is a 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.

Criminal and Civil Liability: You can be criminally liable for failing to make a mandated report. 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 the failure to report.

If you have any questions about the information above, please contact the Office of Human Resources.

ACKNOWLEDGMENT OF MANDATED REPORTING OF ELDER AND DEPENDENT ADULT ABUSE

I understand that while I am employed by the San Mateo County Community College District, I am a mandated reporter of elder and dependent adult abuse under Welfare and Institutions Code Section 15630. I have been provided with a copy of Welfare and Institutions Code Section 15630. As a mandated reporter, I understand that I have a legal obligation to report elder and dependent adult abuse and will comply with the law.

_____	_____	_____
Employee Name	Employee Signature	Date

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LOYALTY OATH FOR NEW EMPLOYEES

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

Employee Name: _____ G#: _____

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.

New employees of the San Mateo County Community College District are required to read, sign and date the Loyalty Oath upon initial hire. Refusal to make this affirmation based upon religious grounds will not serve as a basis for denial of District employment. Employees are required to sign either Signature #1 following the affirmation, **OR** Signature #2 if not affirming based upon religious grounds.

SECTION I: AFFIRMATION

In the State of California, County of San Mateo:

I (print employee name): _____

Do solemnly 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.

SECTION II: EMPLOYEE SIGNATURE

Signature #1:

Witness my hand this _____ Day of _____ In the year _____

Affiant Signature: _____ Date: _____

Signature #2:

I refuse to make the above affirmation based on religious grounds.

Affiant Signature: _____ Date: _____

SECTION III: AUTHORIZED DISTRICT REPRESENTATIVE SIGNATURE

Subscribed and sworn to before me this _____ Day of _____ In the year _____

_____ _____ _____

HR Representative HR Signature Date:

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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

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

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W-2 ELECTRONIC FORM CONSENT

To consent to receive your W-2 electronically, go to WebSMART (https://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 Office of Human Resources or Payroll Office.

By consenting to receive your W-2 form electronically, you agree to go on 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 Office of Human Resources or Payroll Office.

A paper copy of your W-2 form may be obtained by contacting the Office of Human Resources or 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 Name: _____ G#: _____

Employee Signature: _____ Date: _____

Revised March 2019

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1095-C ELECTRONIC CONSENT FORM

To consent to receive your 1095-C electronically, go to WebSMART (https://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 Office of Human Resources or Payroll Office.

By consenting to receive your 1095-C form electronically, you agree to go on WebSMART between January 31 and October 15 of the appropriate year to print your 1095-C form online. You may be required to print and attach your 1095-C 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 1095-C by accessing WebSMART and un-checking the box. You can also complete this form and submit to the Office of Human Resources or Payroll Office.

A paper copy of your 1095-C form may be obtained by contacting the Office of Human Resources or 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 1095-C form electronically: ☐ Cancel consent to receive 1095-C electronically: ☐

I understand the instructions provided to me for accessing and printing my electronic 1095-C form.

Employee Name: _____ G#: _____

Employee Signature: _____ Date: _____

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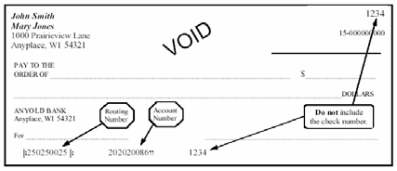
PAYROLL DIRECT DEPOSIT AUTHORIZATION FORM

☐ Initial Request ☐ Change ☐ Cancel

Employee Name: _____ **Employee ID#:** _____

Please attach VOID Check here.

- **Checking account**: For verification purposes, please submit a voided check with this form.
- **Savings account**: Contact your financial institution to obtain its transit routing number.



- Please read and return this completed form to the Payroll Office. Direct deposit goes into effect the following month after the initial request.
- AFT Contract 8.2.3, the district will make payment via direct depositi for payroll checks to all faculty members, unless special circumstances require a paper check to be issued. Employees receivng paper checks as of June 30, 2016 can continue to receive paper checks.
- 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).
- 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 the school district named above, 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 Signature: _____ Date: _____

SAN MATEO COUNTY COMMUNITY COLLEGE DISTRICT

Cañada College • College of San Mateo • Skyline College

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

FACULTY PAYROLL PAY PLAN

☐ **August through May**
(No Payroll check for June and July)

10-MONTH PAY PLAN. Annual salary will be paid and warrants distributed over 10 months of the academic year. All voluntary deductions will be deducted during ten months only. All earnings will be reported to the IRS as paid and no salary warrants will be issued for the months of June and July for August through May pay plan.

I understand that this pay plan is effective for the duration of my faculty employment.

_____
Employee Name

_____
Signature

_____
Date

SAN MATEO COUNTY COMMUNITY COLLEGE DISTRICT

Cañada College • College of San Mateo • Skyline College

CLEAR FORM

ACCOUNTS PAYABLE
3401 CSM DRIVE, SAN MATEO, CA 94402
TELEPHONE: (650) 574-6505 FAX: (650) 574-6574

ACH AUTHORIZATION AGREEMENT (Please TYPE)

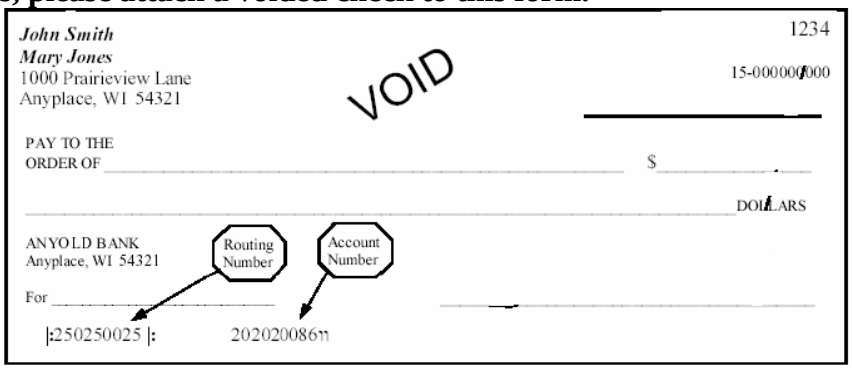
VENDOR / PAYEE NAME	FEDERAL TAX ID NUMBER/SOCIAL SECURITY NUMBER
☐ **Initial Request** ☐ **Change** ☐ **Cancel**	

PRE AUTHORIZED AUTOMATIC DEPOSITS

I (WE) hereby authorize SAN MATEO COUNTY COMMUNITY COLLEGE DISTRICT , hereinafter called SMCCCD, to initiate deposits and, if necessary, debit entries to adjust for any credit entries made in error to my (our) Bank account and the depository institution named below, hereinafter called DEPOSITORY, to credit and/or debit the same to such account.

DEPOSITORY NAME			TYPE OF ACCOUNT ☐ Checking ☐ Savings
BRANCH ADDRESS			TRANSIT/ABA NUMBER
CITY	STATE	ZIP CODE	ACCOUNT NUMBER

For Verification purposes, please attach a voided check to this form.



This authority is to remain in full force and effect until SMCCCD has received written notification from me (or either of us) of its termination in such time and in such manner as to afford SMCCCD and DEPOSITORY a reasonable opportunity to act on it.

SIGNATURE	NAME(S) TITLE	DATE
SIGNATURE	NAME(S) TITLE	DATE
TELEPHONE NUMBER	E-MAIL ADDRESS	

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

2023

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, other details, and privacy.

Step 2: Multiple Jobs or Spouse Works

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

Do **only one** of the following.

(a) Reserved for future use.

(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 . . . . . ☐

TIP: If you have self-employment income, see page 2.

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

Employment Development Department
State of California

Employee's Withholding Allowance Certificate

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

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

1. Use Worksheet A for Regular Withholding allowances. Use other worksheets on the following pages as applicable.
   - 1a. Number of Regular Withholding Allowances (Worksheet A) 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 2023, 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: This certificate, DE 4, is for **California Personal Income Tax (PIT)** withholding purposes only. The DE 4 is used to compute the amount of taxes to be withheld from your wages, by your employer, to accurately reflect your state tax withholding obligation.

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 *Employee's Withholding Allowance Certificate* (DE 4) to determine the appropriate California PIT withholding.

If you do not provide your employer with a withholding certificate, 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.

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

RETIREMENT SYSTEM MEMBERSHIP

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

Employee Name: _____ **Employee ID#:** _____

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, please provide the information below?
Name of the public agency/school district: _____ Date Employment Ended: _____

☐ **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:** 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 (date)** _____

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

CALSTRS Retiree: You cannot work in a classified position except as an instructional aide.

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

Employee Signature: _____ Date: _____

Revised March 2019

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

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

Employee Name _____ **Employee ID#** _____

Employer Name San Mateo County Community C **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.

Here are the steps to expedite your ID card/key requests. To do this we will need some information. Here is a link to the Badge/Key Request form.

Please complete the form with your supervisor and include as much detail as you can. Your employee ID (G#), district email address and the areas you need access will be required. Once the form is complete, return it to your supervisor for approval. The completed form must be sent to the facilities department on your campus for physical keys **and** a copy sent to me for ID card setup and printing. Please list the subject line as "**ID Request – [last name]**". This will make it easier to organize and fulfill your request.

Physical Key requests:

Tatiana Degai – Cañada College Facilities
Alexandra Degai – Skyline College Facilities
Qing Lan (Linda) Liu – CSM Facilities

ID card photographs, ID card printing, programming and activation:

Jason Wendt – CSM Public Safety

In order to print your ID card, I will need a passport style photo of you. I can schedule a time to meet with you and take your photo or, in an effort to expedite this process and promote safety and social distancing, you can send me a digital passport style photo of yourself. The requirements for the photo are that it must be a forward facing photo with a white background. A white wall with no objects in the background will suffice for the background.

If you take the photo with a cell phone then please send it as full size so I can format it properly for your ID card.

*****For security purposes, I request you to send your photo to your supervisor so they confirm your photo and they email it to me. This provides an additional level of security for your ID card.*****

Here is an example of good and bad photos:

You should receive an email indicating the status of your ID card a day or two after we receive these items. Your ID card will be available at the public safety office on your campus with instructions to call 650-738-7000 (Public Safety) should you have any questions.

Please contact me if you have any questions and I will do my best to assist you.

Regards,

Jason Wendt

SAN MATEO COUNTY COMMUNITY COLLEGE DISTRICT

KEY / ID BADGE REQUEST FORM

Step 1: Identifcation - Enter information of the individual receiving key(s) / access credential(s)

Home Campus: ☐ Chancellor's Office ☐ Cañada College ☐ College of San Mateo ☐ Skyline College

Last Name | First Name | MI | G# | Date

Division/Department | Email | Telephone:

Check one: 1 ☐ Permanent 2 ☐ Adjunct 3 ☐ Short-Term* 4 ☐ Contracted* 5 ☐ External Group* 6 ☐ Student Assistant*

*Term End Date: _____

Step 2: Request Type - Select the type of request

(Check all that apply) ☐ Relocation ☐ Modify Access ☐ Damaged Key ☐ Damaged Badge ☐ Lost Key** ☐ Lost Badge** ☐ New Key ☐ New Badge

Step 3: Building Access - List Building and Rooms Requiring Access

Building	Room No. / Space / Area / Description	Facilities Use Only: Key Type	Facilities Use Only: Key / Badge Serial Number

ADDITIONAL INFORMATION: Include access deactivation date/additional information as required.

NOTE: For buildings with electronic access control, a badge will be required to access certain interior doors. The device will also be programmed to provide access to perimeter doors before and after regularly scheduled building usage hours.

**Step 4: Replacement / Lost Key(s)/ Badge - Complete this section

Last Date of Possesion

Details:

Step 5: Signatures

EMPLOYEE SIGNATURE: My signature below indicates that I have read and understand the attached Key and Lock Procedures. I understand the District's keys SHALL NOT be loaned, duplicated or transferred. I also understand that in accordance with California Penal Code Section 469, the duplication of keys or attempt to duplicate keys without authorization is a misdemeanor.

Signature of Employee | Date

Immediate Supervisor (Signature) | Printed Name and Title | Date

College Vice-President/President[1] (Signature) | Printed Name and Title | Date

[1] *(Required for Master Access/Master Key approval only)*

Recipient will be notified via email when key(s) and/or badge is ready for pick up.

PRINT SAVE SUBMIT

TERMS & CONDITIONS RELEASE AGREEMENT

Procedure for District Key and Badge Issuance:
1. This Key Request Form must be completed and photo must be taken before any keys or badge are issued.
2. All key requests must have all required Approval Signatures.
3. Key(s) will only be issued to the individual whose name is on the key request form. Keys shall not be loaned to others or duplicated at anytime.
4. Key(s) will be available for pickup at the Office of the Department of Public Safety for the College that the key(s) are issued for. Valid photo ID must be presented in order to receive key(s).

Use of Keys and Badge:
District keys shall not be loaned or duplicated. California Penal Code 469 states:
Any person who knowingly makes, duplicates, causes to be duplicated, or uses, or attempts to make, duplicate, causes to be duplicated, or use, or has in his/her possession any key to a building or other areas owned, operated or controlled by the State of California, any state agency, board or commission, a county, city or any public school or community college district without authorization from the person in charge of such building or area or his designated representative and with knowledge of the lack of such authorization is guilty of a misdemeanor.

District key(s) are issued for the sole purpose of accessing those building areas which are necessary in order to perform the individual's assigned duties/work. Use of such keys shall be strictly limited to the building areas and timeframes directly associated with performing the individual's assigned duties/work.

All keys and locks issued by the District remain the property of the District and can be recalled at any time.

Return of Keys and Badge:
All District keys and badge must be returned to the Public Safety Office on any campus upon departure of employee or completion of assigned work by Construction and Service Company Personnel. Items must be placed in a sealed envelope with the name of the returnee written clearly on the front.

For Employees Only: The Payroll Office will check with the Public Safety Offices to make sure that all keys have been returned before the individual's final paycheck is distributed. Departures of employees include but are not limited to:
1. Termination/Resignation
2. Leaves of absence that are anticipated to exceed 90 days.

Keys and Badges for Construction and Service Company Personnel:
All construction company and service company personnel must have the approval of a Facilities Manager or the Director of Facilities Maintenance & Operations to obtain a key.

Student Use of Keys and Badge:
Under special circumstances and only when absolutely required, students may be assigned keys or given access to College facilities with approval of a full-time faculty or manager, the appropriate Dean, Vice President, and the Campus Facilities Manager.

Lost or Stolen Keys or Badge:
Lost or stolen keys must be reported immediately to the Public Safety Office or the Campus Facilities Department.
Costs for replacement of lost or stolen keys and re-keying of locks may be charged to the employee or the Division in which the employee works.

CONFIRMATION OF RECEIPT
To be signed by applicant upon receiving keys and/or badge

Signature of Employee | Date

Printed Name

Effective 02.20.2018

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
HR General 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 student 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 paycheck 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 Chief Human Resources Officer.

Previous convictions are reviewed carefully as to the type of violation, regency, severity, and relevance to the type of work for which you are being hired. Criminal record information is processed in the 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 certification 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 the email addresses 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.

Revised April 2022

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

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

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.

Revised March 2019