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SAN MATEO COUNTY COMMUNITY COLLEGE DISTRICT

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

DISTRICT VOLUNTEER SERVICE INFO / FORMS

☐ Skyline College ☐ College of San Mateo ☐ Cañada College ☐ Chancellor's Offc.

Volunteer Name:		Div/Dept:	
Div / Dept Supervisor Name:		Supervisor Tel Num:	
Employee Home Address: City, State, Zip		Home Phone: E-mail:	

In case of emergency, please notify:

(Please Complete by Order of Contact / Minimum of Two Emergency Contacts is Preferred.)

#1 Emergency Contact		**#2 Emergency Contact**	
Name:		**Name:**	
Relationship to Employee:		Relationship to Employee:	
Day/Evening Phone #:		Day/Evening Phone #:	
Home Address: City / State / Zip		Home Address: City / State / Zip	

I will volunteer in this division / dept beginning on (date) _____ and ending on (date) _____ .

I understand that it is my responsibility to update the information included in this form. I understand that I may submit a claim for District Worker's Compensation benefits should any injury occur while performing this volunteer work.

VOLUNTEER SIGNATURE: _____ **DATE:** _____

DIV / DEPT SUPERVISOR SIGNATURE: _____ **DATE:** _____

Please complete the workers' compensation pre-designate personal physician form if you would like to be treated by your personal physician prior to sustaining an injury/illness due to work related injury/illness.

A volunteer assisting in the health center, working with minors, cash-handling or assignment for than one semester will be required to be fingerprinted prior to the start of their volunteer assignment.

Items Included in this Packet:

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VOLUNTEER SERVICES
CONFIDENTIALITY CONTRACT

Confidentiality Contract

Volunteers who are providing service in the SMCCCD and its colleges work in programs and offices that contain confidential records and information. Volunteers are not to seek or use any such information other than that which is necessary to fulfill their assigned duties.

Volunteers must not divulge or otherwise release confidential records or information in written or verbal form to anyone except the person of record, as positively identified with an official government issued picture identification, e.g., DMV issued identification or driver's license, passport. Volunteers should request the assistance of a college staff member before releasing any confidential records or information.

Confidential records or information may be released to appropriate requesting agencies or individuals only after approval from an authorized staff member has been given.

I understand misuse confidential information and records will result in service separation. Additionally, I fully understand that if I divulge or misuse confidential information, my volunteer services will be discontinued and I may be liable to civil and criminal prosecution pursuant to federal and state laws and regulations.

_____	_____	_____
Volunteer Name	Volunteer Signature	Date
_____	_____	_____
Authorized Name	Authorized Signature	Date

3/2014

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VOLUNTEER WORK LOG

VOLUNTEER NAME: _____

DIV. / DEPT. SUPERVISOR NAME _____

DATE	START TIME	END TIME

NEW HIRE WORKERS' COMP PAMPHLET

WORKER'S COMP 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 will be 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.

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.

SUPPLEMENTAL JOB DISPLACEMENT BENEFITS

A non-transferable voucher payable to a state approved school if you are injured on or after 1/1/04, the injury results in a permanent disability, you don't return to work within 60 days after TD ends, and your employer does not offer modified or alternative work. Within 30 days after TD benefits end, your claims examiner will send you a letter outlining whether your employer has a modified job or alternate work available for you and an explanation of your potential rights to a supplemental job displacement benefit. If your employer does not return you to work within 60 days and you have permanent disability, you may chose to receive a nontransferable voucher to use at a state accredited school for education-related retraining or skill replacement. If you qualify for the supplemental job displacement benefit, your claims examiner will provide vouchers up to the maximum established by state law:

1. Up to $4000 for permanent disability awards of more than 0 but less than 15 percent
2. Up to $6000 for permanent disability awards between 15 percent and 25 percent
3. Up to $8000 for permanent disability awards between 26 percent and 49 percent
4. Up to $10,000 for permanent disability awards between 50 percent and 99 percent.

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 Frequently 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 employers 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.

Rev. 2/14

San Mateo County Community College District

workers' compensation: Pre-Designation of Personal Physician

If your employer offers group health insurance and you are injured on the job you have the right to be treated immediately by your personal physician (M.D., D.O) if you notify your employer, in writing, prior to the injury. Per Labor Code 4600 to qualify as the your predesignated, personal physician, the physician must agree, in writing, to treat you for a work related injury, must have previously directed your medical care and must retain your medical history and records. Your predesignated physician must be a general practitioner, family practitioner, board certified or board eligible internist, pediatrician or obstetrician-gynecologist.

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

VOLUNTEER 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 my employer's medical provider. I understand that, at any time in the future, I can change my mind and provide written notification of my personal physician. I understand that the written notification must be on file prior to an industrial injury.

Volunteer Signature: _____ Date: _____

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

Name of Physician _____ Phone Number _____

Physician Address _____

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

Volunteer Signature: _____ Date: _____

A *Personal Physician* must be willing to be predesignated and treat you for a worker's compensation injury.
The remainder of this form is to be completed by your physician and returned to your Employer.

PERSONAL PHYSICIAN ACKNOWLEDGEMENT

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

PERSONAL PHYSICIAN NAME: _____

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

☐ *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. I am not an M.D. or D.O. or do not meet the criteria outlined above.

_____ _____
Physician Signature Date

Please return completed form to:

Human Resources, SMCCCD, 3401 CSM Dr., San Mateo, CA 94402 Fax: (650) 574-6574

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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, and assistant coaches
- 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, students and volunteers, 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 and Post
Building 10 - Room 190
1700 W. Hillsdale Blvd
San Mateo, CA 94402

Skyline College
Graphics Arts & Production
Building 19
3300 College Drive
San Bruno, CA 94066

Cañada College
Bookstore
Building 2
4200 Farm Hill Blvd
Redwood City, CA 94061

Appointments can be made at: **https://app.acuityscheduling.com/schedule.php?owner=12305595**

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.

If you have any questions, please contact the Bookstore staff at each campus:

- CSM (650-574-6367) csmbookstore@smccd.edu
- Skyline (650-738-7014) skylinebookstore@smccd.edu
- Cañada (650-306-3313) canadabookstore@smccd.edu

Your fingerprints will be processed in approximately one 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.

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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.

5/2017

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

Kevin Chak - Skyline Bookstore Manager
Contact Name (mandatory for all school submissions)

SAN MATEO
City

CA
State

94402
ZIP Code

(650) 738-4449
Contact Telephone Number

Applicant Information:

Last Name

First Name | Middle Initial | Suffix

Other Name: (AKA or Alias)

Last Name

First Name | Suffix

Date of Birth

Sex ☐ Male ☐ Female

NA
Driver's License Number

NA
Height

NA
Weight

NA
Eye Color

NA
Hair Color

Billing Number 141009
(Agency Billing Number)

NA
Place of Birth (State or Country)

Social Security Number

Misc. Number NA
(Other Identification Number)

Home Address NA
Street Address or P.O. Box

NA
City

NA
State

NA
ZIP Code

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

Applicant Signature

Date

Your Number: NA
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):

Employer Name

Street Address or P.O. Box

Telephone Number (optional)

City

State

ZIP Code

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