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 CLASSIFIED WELCOME PACKET

INTERNAL USE

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

First Name: _____ Last 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
☐Form I-9 Employment Eligibility Verification
☐Copy of Social Security Card
☐Copy of I-9 documentation employee Provides
☐Child Abuse Reporting Policy
☐Elder Dependent Adult Abuse Reporting Policy
☐Loyalty Oath Policy
☐New Employee Demographics
☐W-4 Employee Withholding Allowance Certificate
☐Electronic W-2 consent Form
☐Payroll Direct Deposit Form
☐ACH Authorization Agreement

☐ Retirement System Membership
☐ CALPERS Reciprocal Self-Certification Form
☐ Hire-Right Background Check and Submission
☐ Proof of Tuberculosis Info & Results
☐ Fingerprinting Info and Receipt of Completion
☐ Electronic 1095-C Consent Form

Notes:

BANNER ENTRY CHECKLIST

☐ PPAIDEN ☐ Biographic ☐ Address ☐ Emergency	☐ PEAEMPL ☐ NBAJOBS	☐ PDABDSU ☐ BENEFIT FORMS ☐ Medical ☐ Dental ☐ Vision ☐ CALPERS ACES ☐ KCARES ☐ PERS Reconciliation	☐ PEAREVW ☐ Fingerprinting ☐ Tuberculosis ☐ Performance Eval ☐ I-9 Tracking	☐ GOATPAC ☐ PEABARG

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HR General Line: (650) 574-6555
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.

Please Click Here for more information regarding our Workers Compensation Notice

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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 February 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. A copy of Welfare and Institutions Code Section 15630 is available upon request. 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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3401 CSM Drive – San Mateo, CA 94403
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Fax: (650) 574-6574

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: _____

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 Representative Signature

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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 February 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: _____

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

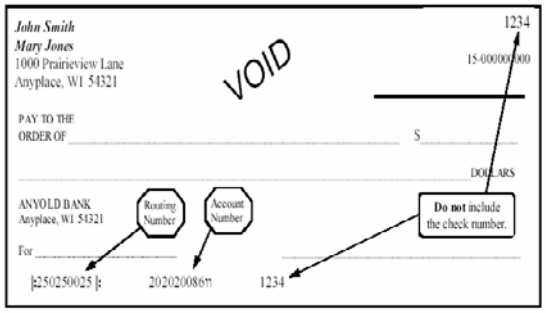
Payroll Office
3401 CSM Drive
San Mateo, CA 94402

PAYROLL DIRECT DEPOSIT AUTHORIZATION FORM

☐ Initial Request ☐ Change ☐ Cancel

Please attach VOID Check here or attach financial institution printout.

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



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

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

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

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

I have read and agree to the foregoing.

Employee Name _____ G# _____ Employee Signature _____ Date _____

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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: _____

Retirement System Election

ES 0372 REV 02/21

[For CalSTRS' Official Use Only]

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

RETIREMENT SYSTEM ELECTION AND ACKNOWLEDGEMENT OF RECEIPT OF RETIREMENT SYSTEM INFORMATION

Please read the attached information and instructions before completing this form. Please type or print legibly in dark ink.

SECTION 1: Member Information and Election (to be completed by employee)

NAME (LAST, FIRST, MIDDLE INITIAL)	SOCIAL SECURITY NUMBER

A member of **CalSTRS** who becomes employed in a new position by the same or a different school district, a community college district, a county superintendent of schools, limited state employment or the Board of Governors of the California Community Colleges, as defined in Education Code sections 22508 and 22508.5, to perform service that *requires* membership in a different public retirement system will have that service credited with that other public retirement system unless the member files a written election (within 60 days after the date of hire) to have that service covered by CalSTRS, pursuant to Education Code section 22508(a) or 22508.5(a).

I am a member of CalSTRS who has accepted employment to perform service that *requires* membership in a different public retirement system and am eligible to elect to continue retirement system coverage under CalSTRS.

I elect coverage in: (please choose one)

☐ CA State Teachers' Retirement System (CalSTRS)

☐ CA Public Employee's Retirement System (CalPERS) *

☐ A Different Public Retirement System identified here:

_____

OR

A member of **CalPERS** who was employed by a school employer, Board of Governors of the California Community Colleges or State Department of Education within 120 days before the member's date of hire, or who has at least five years of CalPERS credited service, as defined in Government Code section 20309, and who is subsequently employed to perform creditable service that requires membership in the Defined Benefit Program of CalSTRS, will have that service credited with CalSTRS unless the member files a written election (within 60 days after the date of hire) to have the service credited with CalPERS, pursuant to Government Code section 20309.

I am a member of CalPERS who has accepted employment to perform service that requires membership in the CalSTRS Defined Benefit Program and am eligible to elect to continue coverage under CalPERS.

I elect coverage in: (please choose one)

☐ CA State Teachers' Retirement System (CalSTRS)

☐ CA Public Employee's Retirement System (CalPERS) *

ES0372

With my signature below, I certify that I have received information from my employer regarding my eligibility to elect membership for this position as described on this form. I fully understand that this election is irrevocable. I understand it is a crime to fail to disclose a material fact or to make any knowingly false material statements for the purpose of altering or receiving a benefit administered by CalSTRS and it may result in up to one year in jail and/or a fine of up to $5,000 pursuant to Education Code section 22010.

EMPLOYEE SIGNATURE	DATE

SECTION 2: Employer Certification (to be completed by employer and County Office of Education)

With my signature below, I certify that I have provided information to the above employee regarding his/her eligibility to elect membership for this position, pursuant to Education Code section 22509. I certify the employee meets the qualifications to make a retirement system election, pursuant to Education Code sections 22508 or 22508.5, or Government Code section 20309.

EMPLOYEE POSITION INFORMATION:

POSITION HIRE	POSITION EFFECTIVE DATE	POSITION TITLE

SELECT ONE: ☐CREDENTIALED ☐CLASSIFIED ☐STATE SERVICE

EMPLOYER INFORMATION:

CO/DIST/STATE DEPT NAME		CALSTRS REPORT UNIT CODE
SCHOOL/STATE OFFICIAL'S NAME	TITLE	PHONE NUMBER
SIGNATURE OF SCHOOL/STATE OFFICIAL		DATE
COUNTY OFFICIAL'S NAME	TITLE	PHONE NUMBER
SIGNATURE OF COUNTY OFFICIAL		CALPERS EMPLOYER CODE

California Public Employees' Retirement System
P.O. Box 942709 Sacramento, CA 94229-2709
888 CalPERS (or **888**-225-7377)
TTY: (877) 249-7442 | Fax: (916) 795-4166
www.calpers.ca.gov

Reciprocal Self-Certification Form

*Complete the following information and return this form to your personnel office **within 10 business days.** To ensure this form is completed correctly, please reference the enclosed List of Qualifying Public Retirement Systems and instructions.*

Section 1. Member Information

Member Name: (Last)	(First)	(Middle)
Date of Birth:	CalPERS ID:	

Membership Status in Qualifying Public Retirement Systems:

☐ I have not been a member of a qualifying public retirement system in California. (skip to section 3)

☐ I have membership in a defined benefit plan under a qualifying public retirement system in California other than CalPERS. (complete section 2 with membership information for each qualifying public retirement system)

Section 2. Qualifying Reciprocal Membership Information

Name of Most Recent Public Retirement System:	Membership Date: / /	Separation Date*: / /	☐Retired* or ☐Refunded* Date: / /
Name of Prior Public Retirement System:	Membership Date: / /	Separation Date*: / /	☐Retired* or ☐Refunded* Date: / /
Name of Prior Public Retirement System:	Membership Date: / /	Separation Date*: / /	☐Retired* or ☐Refunded* Date: / /

**Please provide dates, if applicable. Not all sections may be applicable for each Public Retirement System.*

Section 3. Sign and Certify

I understand that by accepting employment in a qualified public retirement system, I am subject to the applicable laws and regulations of that system. **I also understand that completing this form is not a request to establish reciprocity.**

I hereby certify that the foregoing information has been verified with the qualifying public retirement system as true and correct and any information found to be incorrect may require corrections to my CalPERS account including, but not limited to, my retirement enrollment level and adjustments to my member contributions. CalPERS may make any necessary corrections to my account to ensure I am properly enrolled and eligible to receive the correct retirement benefits.

Member Signature: *Date:*

Section 4. To Be Completed by Employer Only

Name of CalPERS Agency:	
CalPERS Business Partner ID:	Member's Enrollment Eligibility Date:
Designee of Employer: (print name)	Designees' Title:
Designee Signature:	*Date:*

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

For more direction regarding how to process the Reciprocal Self-Certification Form, please refer to our employer reference guides.

List of Qualifying Public Retirement Systems in California

Name of Public Retirement System	Qualifications:
Alameda County Employees' Retirement Association^	
City and County of San Francisco Employees' Retirement System*	
City of Concord Retirement System*	
City of Costa Mesa Public Retirement System*	Safety only
City of Fresno Retirement System	
City of Pasadena Fire and Police Retirement System	Fire and police only
City of San Clemente*	Non-safety (miscellaneous) only
Contra Costa County Employees' Retirement Association^	
Contra Costa Water District	
East Bay Municipal Utility District	
East Bay Regional Park District	Safety only
Fresno County Employees' Retirement Association^	
Imperial County Employees' Retirement Association^	
Judges Retirement System II	
Kern County Employees' Retirement System^	
Legislators' Retirement System	
Los Angeles City Employees' Retirement System	Non-safety (miscellaneous) only; L.A. Fire and Police Pension System and L.A. Water and Power Employees' Retirement System not eligible
Los Angeles County Employees' Retirement Association^	
Los Angeles County Metropolitan Transportation Authority	Non-contract Employees' Retirement Income Plan, formerly Southern California Rapid Transit District
Marin County Employees' Retirement Association^	
Mendocino County Employees' Retirement Association^	
Merced County Employees' Retirement Association^	
Oakland Municipal Employees' Retirement System (City of Oakland)	Non-safety (miscellaneous) only
Orange County Employees' Retirement System^	
Sacramento City Employees' Retirement System*	
Sacramento County Employees' Retirement System^	Defined benefit plan only; cash balance plans not eligible
San Bernardino County Retirement Association^	
San Diego City Employees' Retirement System	Defined benefit plan only; cash balance plans not eligible
San Diego County Employees' Retirement Association^	
San Joaquin County Employees' Retirement Association^	
San Jose Federated City Employees' Retirement System	
San Luis Obispo County Pension Trust	
San Mateo County Employees' Retirement Association^	
Santa Barbara County Employees' Retirement System^	
Sonoma County Employees' Retirement Association^	
Stanislaus County Employees' Retirement Association^	
State Teachers' Retirement System	Defined benefit plan only; cash balance plans not eligible
Tulare County Employees' Retirement Association^	
University of California Retirement Program	Defined benefit plan only; cash balance plans not eligible
Ventura County Employees' Retirement Association^	

*=Also CalPERS-covered agency ^=1937 Act Counties

Form **W-4**

Department of the Treasury
Internal Revenue Service

Employee's Withholding Certificate

Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay.
Give Form W-4 to your employer.
Your withholding is subject to review by the IRS.

OMB No. 1545-0074

2024

Step 1: Enter Personal Information

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

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

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

Step 2: Multiple Jobs or Spouse Works

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

Do **only one** of the following.

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

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

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

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

Step 3: Claim Dependent and Other Credits

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

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

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

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

Step 4 (optional): Other Adjustments

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

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

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

Step 5: Sign Here

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

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

Employers Only

Employer's name and address	First date of employment	Employer identification number (EIN)

Employment Development Department
State of California

Clear Form

Employee's Withholding Allowance Certificate

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

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

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

OR

Exemption from Withholding

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

OR

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

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

Employee's Signature _____ Date _____

Employer's Section: Employer's Name and Address	California Employer Payroll Tax Account Number

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

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

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

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

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

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

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

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

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

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

(iii) You maintain your domicile in another state.

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

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 | N/A
Suffix

Other Name: (AKA or Alias)

Last Name

First Name | N/A
Suffix

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

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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.