Chaffey College
Career Services

Responsibilities of a Chaffey College Student Employee

1. I understand that I must read, complete, and sign **all** required employment documents **prior to my first day of work**. I understand that failure to complete these documents and allow them to be processed by the Student Employment Office will affect my ability to work and/or my ability to receive a payroll warrant. The documents to be completed include, but may not be limited to:
   - **Responsibilities of a Chaffey College Student Employee** (this page) 1
   - **Oath of Allegiance** 2
   - **Employee Information** 3
   - **Student Payroll Information Sheet with Timesheet Example** 4
   - **Warrant Beneficiary Designation** 5
   - **Payroll Advice Disposition** 6
   - **Waiver for Warrant Mailing** 7
   - **Supplemental Employment Application** 8
   - **Employee's Withholding Allowance Certificate** 9-12
   - **Form I-9, Employment Eligibility Verification** 13-15
   - **Form W-4, Employee's Withholding Certificate** 16-19
   - **Acknowledgment of Documentation** (see Student Employment Information Packet)
2. I agree to arrange a mutually agreed upon work schedule with my immediate supervisor and to consistently adhere to that schedule. I understand that all changes to my work schedule must be approved by my immediate supervisor in advance of the date of change.
3. I agree to report to work on time and with regularity. I understand that if I am unable to report to work or if I will be reporting late due to an illness or other unavoidable reason, I must contact my immediate supervisor *personally* prior to my report time or as early in the work day as possible.
4. I understand that my position as a student employee requires that I conduct myself in a professional manner. Furthermore, I agree to maintain confidentiality regarding any sensitive information to which I may be privileged by virtue of my student employee position and understand that a breach of confidentiality or any act of dishonesty is just cause for immediate dismissal.
5. I agree, when circumstances allow, to give my immediate supervisor a minimum two-week notice of my intention to resign.
6. I understand that whenever possible the proper procedure for discussing work site concerns and grievances dictates that I discuss them first with my immediate supervisor.
7. I understand that it is my responsibility to submit a properly completed timesheet to my immediate supervisor by the agreed upon date. I understand that my failure to do so may delay my payroll warrant for that pay period.

I, the undersigned, affirm that I have read the above statements and agree with the terms therein. I understand that I may seek the assistance of the Student Employment Office when completing any required employment documents. I understand that a copy of this agreement will be available to my supervisor. I understand that I must maintain enrollment in at least six (6) units and a 2.0 cumulative GPA in order to participate in the student employment program.

_____ _____

Student Employee Signature Date (mm/dd/yyyy)

_____ _____

Received by (Student Employment Office Staff) Date

Chaffey College

OATH OF ALLEGIANCE FOR PERSONS EMPLOYED BY A SCHOOL DISTRICT OF THE STATE OF CALIFORNIA

(Required by Article 20, Section 3, California Constitution)

State of California)
ss
County of San Bernardino)

I, _____, do
(Type or Print Name)

solemnly swear (or affirm) that I will support and defend the Constitution of the United States and the Constitution of the State of California against all enemies, foreign and domestic; that I will bear true faith and allegiance to the Constitution of the United States and 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.

Please sign in presence of HR Representative

_____

Signature of Employee

Taken, subscribed and sworn to before me this ____ day _____, 20 ___

_____

Signature of Authorized Official
Human Resources

Chaffey College
Office of Human Resources

(Check one)
☐ New Hire
☐ Name Change
☐ Address Change
☐ Other

EMPLOYEE INFORMATION

Date _____ **Social Security Number** _____ **Employee ID#** _____

Legal Name (do not use nicknames)

_____ _____ _____ _____
Last Name **First Name** **Middle Name** **Suffix (Jr., Sr.)**

Name Change Information **For name change, please check reason below:**

_____ ☐ Marriage ☐ Divorce ☐ Other _____
Former Last Name

Physical Address (do not use a PO Box)

_____ _____ CA _____
Street **City** **State** **Zip**

_____ _____ _____
Email address **Home Phone** **Cell Phone**

Mailing Address (if different)

_____ _____ _____ _____
Street **City** **State** **Zip**

Emergency Contact

_____ _____ _____
Emergency Contact Name **Relationship** **Emergency Phone**

_____ _____ _____ _____ _____
Street **City** **State** **Zip** **Home Phone**

DEMOGRAPHIC INFORMATION (used for mandated State and Federal reports)

_____
Date of Birth

Disability? ☐ Yes ☐ No
(based on the definition to the right)

☐ Male ☐ Female

Over 40 Years Old? ☐ Yes ☐ No

DEFINITION: An individual with a disability is defined by the DFEH as a person who has a physical or mental impairment that limits one or more major life activities, or a person who has a history or record of such impairment, or a person who is perceived by others as having such impairment.

Ethnicity/Race

Are you Hispanic or Latino? ☐ Yes ☐ No

- ☐ Mexican, Mexican/American, Chicano (HM)
- ☐ Central American (HR)
- ☐ South American (HS)
- ☐ Hispanic Other (HX)

If not Hispanic, what is your race/ethnicity? *(check one or more)*

- ☐ Chinese (AC)
- ☐ Asian Indian (AI)
- ☐ Japanese (AJ)
- ☐ Korean (AK)
- ☐ Laotian (AL)
- ☐ Cambodian (AM)
- ☐ Vietnamese (AV)
- ☐ Asian Other (AX)
- ☐ Filipino (F)
- ☐ Black or African American (B)
- ☐ American Indian/Alaskan Native (N)
- ☐ Guamanian (PG)
- ☐ Hawaiian (PH)
- ☐ Samoan (PS)
- ☐ Pacific Islander Other (PX)
- ☐ White (W)

Chaffey College
Career Services

Student Payroll Information

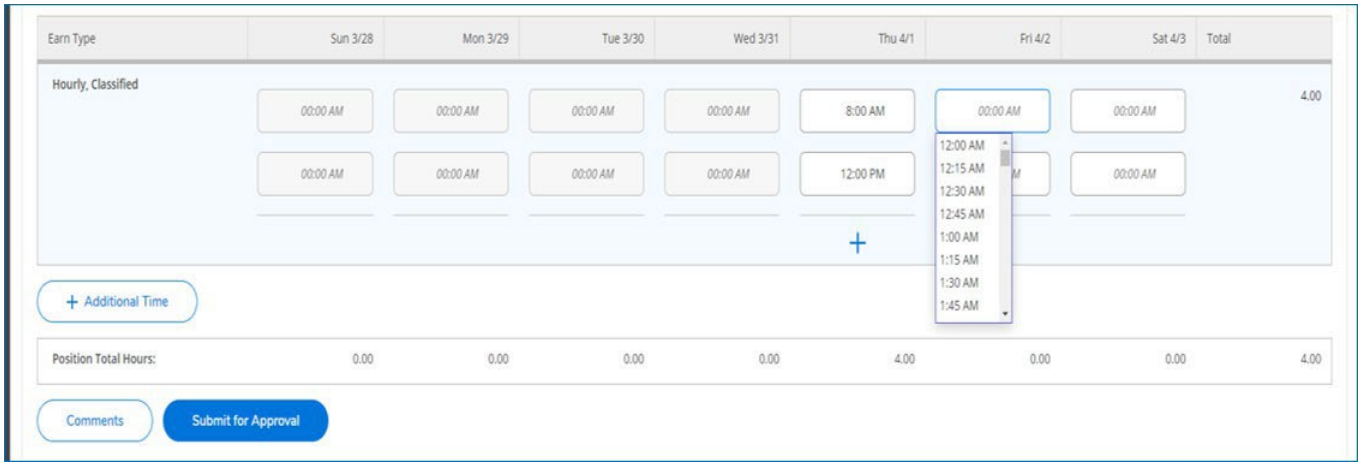
1. Student employment is short-term, temporary, and may not exceed 20 hours per week (or 35 hours per week when school is not it session).
2. Pay periods begin on the 1st of each month and end on the last day of the month.
3. Paychecks are issued on the 15th of each month. If the 15th falls on a weekend or holiday, checks will be issued the next business day.
4. Compensation is based on actual time worked; e.g., you will not be compensated for days off due to illness, vacation, jury duty, holidays, semester breaks, etc.
5. The District has the right to terminate your employment at any time. As an "at will" employee, you do not have reasonable assurance of continued work. Therefore, during breaks in employment you may be eligible to apply for unemployment and may file a claim with the Employment Development Department (EDD). Your entitlement for benefits will be determined by EDD and not by the District.

_____ _____

Employee Signature Date

Self-Service Web-Time Timesheet

- Hours worked should be logged daily.
- Timesheets must be electronically signed before submission each month.



Chaffey College
Career Services

WARRANT(S) BENEFICIARY DESIGNATION

Under the provisions of *Section 53245* of the California Government Code, in the event of my death I hereby designate the following named person to be entitled to receive and have issued in their name all outstanding pay warrant(s) due to me by Chaffey College had I survived. (Note, if designated beneficiary is the spouse of employee, Chaffey College will issue final pay warrant(s) 'to the estate of,' said employee.)

_____ _____

Print Designee's Name in Full Relationship to Employee

_____

Designee's Complete Address (Street, City, State, and Zip)

This designation cancels and replaces any previously signed by me for this purpose and shall remain in effect until canceled in writing by me.

It is expressly understood and agreed that the Chaffey Community College District is not obligated to deliver said warrant(s) to the person designated herein above unless said designated person within two years after the date of said warrant(s) claims from Chaffey College and provides to Chaffey College sufficient proof of identity pursuant to the provisions of *Section 53245* of the California Government Code.

_____ _____

Employee's Signature Date

_____

Witness / Student Employment Office Staff

Chaffey College

PAYROLL DISPOSITION FORM

EFT AUTHORIZATION FORM

NAME:_____ COLLEAGUE ID NUMBER:_____

EMPLOYMENT PAY TYPE: ☐Academic Contract ☐Classified Contract
☐Academic Hourly/Adjunct ☐Short Term Worker/Student

REQUEST TYPE: ☐ New Authorization ☐ Update Authorization

I HEREBY REQUEST THAT MY PAYROLL WARRANT BE:

☐ **MAILED TO ADDRESS ON FILE** (sign Waiver on reverse) ☐ **PICKED UP FROM PAYROLL OFFICE**

☐ **ELECTRONICALLY TRANSFERRED TO MY BANK** (attach voided check or provide bank information below)

Bank Name:_____

Amount: ☐ Total Net Pay or ☐ $_____ or ☐ Cancel

Account #_____ Bank's 9-digit Routing #_____

Account Type: ☐ Checking ☐ Savings

Bank Name:_____

Amount: ☐ Remaining Balance or ☐ $_____ or ☐ Cancel

Account #_____ Bank's 9-digit Routing #_____

Account Type: ☐ Checking ☐ Savings

Bank Name:_____

Amount: ☐ Remaining Balance or ☐ $_____ or ☐ Cancel

Account #_____ Bank's 9-digit Routing #_____

Account Type: ☐ Checking ☐ Savings

ELECTRONIC FUND TRANSFER TAKES EFFECT ONLY AFTER A SUCCESSFUL PRENOTE TEST HAS OCCURRED THROUGH THE BANKING SYSTEM. TYPICALLY, THE NEXT PAY PERIOD.

I, _____ shall hold harmless and indemnity Chaffey Community College District herein after referred to as District, and its officers and employees from any claim or demand of whatever nature of the District and its officers and employees, brought by any person, including any banking institution against the District in its capacity as an employer concerning the Payroll Warrant Disposition provided by the District.

I hereby authorize the District to initiate credit entries and, if necessary, debit entries and adjustments for any credit entries in error to my account indicated above. I also authorize the Depository Credit Union/Bank named above, to credit and/or debit the same to such account. The request completed above is for the monthly disposition of my pay warrant from the first payroll after the date this form is signed until rescinded in writing.

Signature:_____ Date:_____

FOR BUSINESS OFFICE USE ONLY:

Prenote payroll date: _____

EFT date: _____

Rev. 10/2023

Chaffey College

PAYROLL DEPARTMENT

WAIVER FOR WARRANT MAILING

I, _____, shall keep and save free and harmless the Chaffey Community College District, its officers, agents, and employees for any loss or delay of my pay warrant due to the deposit of same in the U.S. mail system.

I also understand and agree that per Government Code Section 29853, a warrant cannot be considered lost until and unless it has not been received by the addressee within twenty (20) days after date of mailing, unless a shorter period of time is established by the action of the Board of Supervisors.

Further, I acknowledge that payroll warrants replaced by an Accounts Payable check shall be only in the amount not to exceed 90% of the calculated net pay and the balance to be paid on the next payroll. If a District warrant is issued to replace the lost warrant ***AND*** the District has issued an Accounts Payable check as noted above, I will reimburse, upon receipt of the District warrant, the Accounts Payable fund in the amount of the temporary advance.

_____
Signature

_____
Date

Chaffey College
Career Services

Supplemental Employment Application

Name: _____ Chaffey ID Number: _____
Last First MI

Home Phone: _____ Cell Phone: _____ Dept: _____

RELATIVES

Do you have any relatives, by blood or law, who are currently employed by the Chaffey Community College District? ☐ Yes ☐ No If yes, who?

Name	Relationship	Work Site / Department

CONVICTIONS

As part of our responsibility to students and to the public, it is important to be extremely careful in screening applicants with conviction records. You may be disqualified from an examination, or dismissed from employment with the Chaffey Community College District unless you fill out this form accurately and completely.

A conviction includes a plea of guilty, and/or finding of guilty by a judge or a jury, even if such conviction was later dismissed pursuant to Penal Code section 1203.4. ***Convictions that are dismissed under Penal Code section 1203.4 are not "expunged" for this purpose and must be disclosed.*** They will appear on the report prepared by the California Department of Justice and/or Federal Bureau of Investigation.

Have you ever been convicted, fined or placed on probation for any violation of law? ☐ Yes ☐ No

You may omit the following:

- Minor traffic infractions and offenses adjudicated in juvenile court;
- If you have been convicted of a drug offense in Health and Safety Code sections 11357, 11360, 11364 or 11365, or a statutory predecessor of these statues which is over two years old.

INSTRUCTIONS

In the spaces below, give complete details for every time you have been convicted, fined, placed on probation, sentenced or given a suspended sentence for any violation of law. If you are in doubt, list the conviction and explain. If you are a finalist for a position with our District and a conviction appears on your records which you have not listed, you will be denied employment. Attach additional sheets if necessary.

Offense (Brief Description)	Offense Code No.	Date Mo/Yr	Location (City & State)	Infraction	Misdemeanor	Felony	Imprisoned	Fined	Probation
				◯	◯	◯	◯	◯	◯
				◯	◯	◯	◯	◯	◯
				◯	◯	◯	◯	◯	◯

DECLARATION

I declare that I have read and understand all of the questions and statements listed above and the answers I have given are true and correct.

_____ _____
Student Employee Signature Date

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
Chaffey College 5885 Haven Ave. Rancho Cucamonga, CA 91737	800-9608-4

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.

The *California Employer's Guide* (DE 44) (edd.ca.gov/pdf_pub_ctr/de44.pdf) provides the income tax withholding tables. This publication may be found by visiting Payroll Taxes - Forms and Publications (edd.ca.gov/Payroll_Taxes/Forms_and_Publications.htm). To assist you in calculating your tax liability, please visit the Franchise Tax Board (FTB) (ftb.ca.gov).

If you need information on your last *California Resident Income Tax Return* (FTB Form 540), visit the FTB (ftb.ca.gov).

Notification: The burden of proof rests with the employee to show the correct California income tax withholding. Pursuant to section 4340-1(e) of Title 22, California Code of Regulations (CCR) (govt.westlaw.com/calregs/Search/Index), the FTB or the EDD may, by special direction in writing, require an employer to submit a Form W-4 or DE 4 when such forms are necessary for the administration of the withholding tax programs.

Penalty: You may be fined $500 if you file, with no reasonable basis, a DE 4 that results in less tax being withheld than is properly allowable. In addition, criminal penalties apply for willfully supplying false or fraudulent information or failing to supply information requiring an increase in withholding. This is provided by section 13101 of the California Unemployment Insurance Code (leginfo.legislature.ca.gov/faces/codes.xhtml) and section 19176 of the Revenue and Taxation Code (leginfo.legislature.ca.gov/faces/codes.xhtml).

Worksheets

Instructions — 1 — Allowances*

When determining your withholding allowances, you must consider your personal situation:
— Do you claim allowances for dependents or blindness?
— Will you itemize your deductions?
— Do you have more than one income coming into the household?

Two-Earners/Multiple Incomes: When earnings are derived from more than one source, under-withholding may occur. If you have a working spouse or more than one job, it is best to check the box "SINGLE or MARRIED (with two or more incomes)." Figure the total number of allowances you are entitled to claim on all jobs using only one DE 4 form. Claim allowances with **one** employer.

Do **not** claim the same allowances with more than one employer. Your withholding will usually be most accurate when all allowances are claimed on the DE 4 filed for the highest paying job and zero allowances are claimed for the others.

Married But Not Living With Your Spouse: You may check the "Head of Household" marital status box if you meet all of the following tests:
(1) Your spouse will not live with you **at any time** during the year;
(2) You will furnish over half of the cost of maintaining a home for the entire year for yourself and your child or stepchild who qualifies as your dependent; **and**
(3) You will file a separate return for the year.

Head of Household: To qualify, you must be unmarried or legally separated from your spouse and pay more than 50% of the costs of maintaining a home for the **entire** year for yourself and your dependent(s) or other qualifying individuals. Cost of maintaining the home includes such items as rent, property insurance, property taxes, mortgage interest, repairs, utilities, and cost of food. It does not include the individual's personal expenses or any amount which represents value of services performed by a member of the household of the taxpayer.

Worksheet A — **Regular Withholding Allowances**

(A)	Allowance for yourself — enter 1	(A)
(B)	Allowance for your spouse (if not separately claimed by your spouse) — enter 1	(B)
(C)	Allowance for blindness — yourself — enter 1	(C)
(D)	Allowance for blindness — your spouse (if not separately claimed by your spouse) — enter 1	(D)
(E)	Allowance(s) for dependent(s) — do not include yourself or your spouse	(E)
(F)	Total — add lines (A) through (E) above and enter on line 1a of the DE 4	(F) 0

Instructions — 2 — (Optional) Additional Withholding Allowances

If you expect to itemize deductions on your California income tax return, you can claim additional withholding allowances. Use Worksheet B to determine whether your expected estimated deductions may entitle you to claim **one or more additional** withholding allowances. Use last year's FTB Form 540 as a model to calculate this year's withholding amounts.

Do not include deferred compensation, qualified pension payments, or flexible benefits, etc., that are deducted from your gross pay but are not taxed on this worksheet.

You may reduce the amount of tax withheld from your wages by claiming one additional withholding allowance for each $1,000, or fraction of $1,000, by which you expect your estimated deductions for the year to exceed your allowable standard deduction.

Worksheet B — **Estimated Deductions**

Use this worksheet **only** if you plan to itemize deductions, claim certain adjustments to income, or have a large amount of nonwage income not subject to withholding.

1.	Enter an estimate of your itemized deductions for California taxes for this tax year as listed in the schedules in the FTB Form 540		1.
2.	Enter $10,726 if married filing joint with two or more allowances, unmarried head of household, or qualifying widow(er) with dependent(s) or $5,363 if single or married filing separately, dual income married, or married with multiple employers	–	2.
3.	Subtract line 2 from line 1, enter difference	=	3. 0.00
4.	Enter an estimate of your adjustments to income (alimony payments, IRA deposits)	+	4.
5.	Add line 4 to line 3, enter sum	=	5. 0.00
6.	Enter an estimate of your nonwage income (dividends, interest income, alimony receipts)	–	6.
7.	If line 5 is greater than line 6 (if less, see below [go to line 9]); Subtract line 6 from line 5, enter difference	=	7. 0.00
8.	Divide the amount on line 7 by $1,000, round any fraction to the nearest whole number enter this number on line 1b of the DE 4. Complete Worksheet C, if needed, otherwise **stop here**.		8. 0.00
9.	If line 6 is greater than line 5; Enter amount from line 6 (nonwage income)		9.
10.	Enter amount from line 5 (deductions)		10. 0.00
11.	Subtract line 10 from line 9, enter difference. Then, complete Worksheet C.		11. 0.00

*Wages paid to registered domestic partners will be treated the same for state income tax purposes as wages paid to spouses for California PIT withholding and PIT wages. This law does not impact federal income tax law. A registered domestic partner means an individual partner in a domestic partner relationship within the meaning of section 297 of the Family Code. For more information, please call our Taxpayer Assistance Center at 1-888-745-3886.

Worksheet C **Additional Tax Withholding and Estimated Tax**

1.	Enter estimate of total wages for tax year 2024.	1.	
2.	Enter estimate of nonwage income (line 6 of Worksheet B).	2.	
3.	Add line 1 and line 2. Enter sum.	3.	
4.	Enter itemized deductions or standard deduction (line 1 or 2 of Worksheet B, whichever is largest).	4.	
5.	Enter adjustments to income (line 4 of Worksheet B).	5.	
6.	Add line 4 and line 5. Enter sum.	6.	
7.	Subtract line 6 from line 3. Enter difference.	7.	0.00
8.	Figure your tax liability for the amount on line 7 by using the 2024 tax rate schedules below.	8.	
9.	Enter personal exemptions (line F of Worksheet A x $158.40).	9.	0.00
10.	Subtract line 9 from line 8. Enter difference.	10.	0.00
11.	Enter any tax credits. (See FTB Form 540).	11.	
12.	Subtract line 11 from line 10. Enter difference. This is your total tax liability.	12.	0.00
13.	Calculate the tax withheld and estimated to be withheld during 2024. Contact your employer to request the amount that will be withheld on your wages based on the marital status and number of withholding allowances you will claim for 2024. Multiply the estimated amount to be withheld by the number of pay periods left in the year. Add the total to the amount already withheld for 2024.	13.	
14.	Subtract line 13 from line 12. Enter difference. If this is less than zero, you do not need to have additional taxes withheld.	14.	0.00
15.	Divide line 14 by the number of pay periods remaining in the year. Enter this figure on line 2 of the DE 4.	15.	

Note: Your employer is not required to withhold the additional amount requested on line 2 of your DE 4. If your employer does not agree to withhold the additional amount, you may increase your withholdings as much as possible by using the “single” status with “zero” allowances. If the amount withheld still results in an underpayment of state income taxes, you may need to file quarterly estimates on Form 540-ES with the FTB to avoid a penalty.

These Tables Are for Calculating Worksheet C and for 2024 Only

Single Persons, Dual Income Married or Married With Multiple Employers

IF THE TAXABLE INCOME IS		COMPUTED TAX IS		
OVER	BUT NOT OVER	OF AMOUNT OVER...		PLUS
$0	$10,412	1.100%	$0	$0.00
$10,412	$24,684	2.200%	$10,412	$114.53
$24,684	$38,959	4.400%	$24,684	$428.51
$38,959	$54,081	6.600%	$38,959	$1,056.61
$54,081	$68,350	8.800%	$54,081	$2,054.66
$68,350	$349,137	10.230%	$68,350	$3,310.33
$349,137	$418,961	11.330%	$349,137	$32,034.84
$418,961	$698,271	12.430%	$418,961	$39,945.90
$698,271	$1,000,000	13.530%	$698,271	$74,664.13
$1,000,000	and over	14.630%	$1,000,000	$115,488.06

Married Persons

IF THE TAXABLE INCOME IS		COMPUTED TAX IS		
OVER	BUT NOT OVER	OF AMOUNT OVER...		PLUS
$0	$20,824	1.100%	$0	$0.00
$20,824	$49,368	2.200%	$20,824	$229.06
$49,368	$77,918	4.400%	$49,368	$857.03
$77,918	$108,162	6.600%	$77,918	$2,113.23
$108,162	$136,700	8.800%	$108,162	$4,109.33
$136,700	$698,274	10.230%	$136,700	$6,620.67
$698,274	$837,922	11.330%	$698,274	$64,069.69
$837,922	$1,000,000	12.430%	$837,922	$79,891.81
$1,000,000	$1,396,542	13.530%	$1,000,000	$100,038.11
$1,396,542	and over	14.630%	$1,396,542	$153,690.24

Unmarried/Head of Household

IF THE TAXABLE INCOME IS		COMPUTED TAX IS		
OVER	BUT NOT OVER	OF AMOUNT OVER...		PLUS
$0	$20,839	1.100%	$0	$0.00
$20,839	$49,371	2.200%	$20,839	$229.23
$49,371	$63,644	4.400%	$49,371	$856.93
$63,644	$78,765	6.600%	$63,644	$1,484.94
$78,765	$93,037	8.800%	$78,765	$2,482.93
$93,037	$474,824	10.230%	$93,037	$3,738.87
$474,824	$569,790	11.330%	$474,824	$42,795.68
$569,790	$949,649	12.430%	$569,790	$53,555.33
$949,649	$1,000,000	13.530%	$949,649	$100,771.80
$1,000,000	and over	14.630%	$1,000,000	$107,584.29

If you need information on your last California Resident Income Tax Return, FTB Form 540, visit (FTB) (ftb.ca.gov).

The DE 4 information is collected for purposes of administering the PIT law and under the authority of Title 22, CCR, section 4340-1, and the California Revenue and Taxation Code, including section 18624. The Information Practices Act of 1977 requires that individuals be notified of how information they provide may be used. Further information is contained in the instructions that came with your last California resident income tax return.

Employment Eligibility Verification

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Additional Information

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

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

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

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

Employer's Business or Organization Name	Employer's Business or Organization Address, City or Town, State, ZIP Code
Chaffey College	5885 Haven Ave., Rancho Cucamonga, CA 91737

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

LISTS OF ACCEPTABLE DOCUMENTS

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

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

Acceptable Receipts

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Supplement B,
Reverification and Rehire (formerly Section 3)

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

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

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

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

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

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

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

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

Additional Information (Initial and date each notation.)

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

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

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

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

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

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

Additional Information (Initial and date each notation.)

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

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

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

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

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

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

Additional Information (Initial and date each notation.)

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

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)
Chaffey College 5885 Haven Ave. Rancho Cucamonga, CA 91737		95-6000558

General Instructions

Section references are to the Internal Revenue Code.

Future Developments

For the latest information about developments related to Form W-4, such as legislation enacted after it was published, go to *www.irs.gov/FormW4*.

Purpose of Form

Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay. If too little is withheld, you will generally owe tax when you file your tax return and may owe a penalty. If too much is withheld, you will generally be due a refund. Complete a new Form W-4 when changes to your personal or financial situation would change the entries on the form. For more information on withholding and when you must furnish a new Form W-4, see Pub. 505, Tax Withholding and Estimated Tax.

Exemption from withholding. You may claim exemption from withholding for 2024 if you meet both of the following conditions: you had no federal income tax liability in 2023 **and** you expect to have no federal income tax liability in 2024. You had no federal income tax liability in 2023 if (1) your total tax on line 24 on your 2023 Form 1040 or 1040-SR is zero (or less than the sum of lines 27, 28, and 29), or (2) you were not required to file a return because your income was below the filing threshold for your correct filing status. If you claim exemption, you will have no income tax withheld from your paycheck and may owe taxes and penalties when you file your 2024 tax return. To claim exemption from withholding, certify that you meet both of the conditions above by writing "Exempt" on Form W-4 in the space below Step 4(c). Then, complete Steps 1(a), 1(b), and 5. Do not complete any other steps. You will need to submit a new Form W-4 by February 15, 2025.

Your privacy. Steps 2(c) and 4(a) ask for information regarding income you received from sources other than the job associated with this Form W-4. If you have concerns with providing the information asked for in Step 2(c), you may choose Step 2(b) as an alternative; if you have concerns with providing the information asked for in Step 4(a), you may enter an additional amount you want withheld per pay period in Step 4(c) as an alternative.

When to use the estimator. Consider using the estimator at *www.irs.gov/W4App* if you:

1. Expect to work only part of the year;

2. Receive dividends, capital gains, social security, bonuses, or business income, or are subject to the Additional Medicare Tax or Net Investment Income Tax; or

3. Prefer the most accurate withholding for multiple job situations.

Self-employment. Generally, you will owe both income and self-employment taxes on any self-employment income you receive separate from the wages you receive as an employee. If you want to pay these taxes through withholding from your wages, use the estimator at *www.irs.gov/W4App* to figure the amount to have withheld.

Nonresident alien. If you're a nonresident alien, see Notice 1392, Supplemental Form W-4 Instructions for Nonresident Aliens, before completing this form.

Specific Instructions

Step 1(c). Check your anticipated filing status. This will determine the standard deduction and tax rates used to compute your withholding.

Step 2. Use this step if you (1) have more than one job at the same time, or (2) are married filing jointly and you and your spouse both work.

Option **(a)** most accurately calculates the additional tax you need to have withheld, while option **(b)** does so with a little less accuracy.

Instead, if you (and your spouse) have a total of only two jobs, you may check the box in option **(c)**. The box must also be checked on the Form W-4 for the other job. If the box is checked, the standard deduction and tax brackets will be cut in half for each job to calculate withholding. This option is accurate for jobs with similar pay; otherwise, more tax than necessary may be withheld, and this extra amount will be larger the greater the difference in pay is between the two jobs.

Multiple jobs. *Complete Steps 3 through 4(b) on only one Form W-4. Withholding will be most accurate if you do this on the Form W-4 for the highest paying job.*

Step 3. This step provides instructions for determining the amount of the child tax credit and the credit for other dependents that you may be able to claim when you file your tax return. To qualify for the child tax credit, the child must be under age 17 as of December 31, must be your dependent who generally lives with you for more than half the year, and must have the required social security number. You may be able to claim a credit for other dependents for whom a child tax credit can't be claimed, such as an older child or a qualifying relative. For additional eligibility requirements for these credits, see Pub. 501, Dependents, Standard Deduction, and Filing Information. You can also include **other tax credits** for which you are eligible in this step, such as the foreign tax credit and the education tax credits. To do so, add an estimate of the amount for the year to your credits for dependents and enter the total amount in Step 3. Including these credits will increase your paycheck and reduce the amount of any refund you may receive when you file your tax return.

Step 4 (optional).

Step 4(a). Enter in this step the total of your other estimated income for the year, if any. You shouldn't include income from any jobs or self-employment. If you complete Step 4(a), you likely won't have to make estimated tax payments for that income. If you prefer to pay estimated tax rather than having tax on other income withheld from your paycheck, see Form 1040-ES, Estimated Tax for Individuals.

Step 4(b). Enter in this step the amount from the Deductions Worksheet, line 5, if you expect to claim deductions other than the basic standard deduction on your 2024 tax return and want to reduce your withholding to account for these deductions. This includes both itemized deductions and other deductions such as for student loan interest and IRAs.

Step 4(c). Enter in this step any additional tax you want withheld from your pay **each pay period**, including any amounts from the Multiple Jobs Worksheet, line 4. Entering an amount here will reduce your paycheck and will either increase your refund or reduce any amount of tax that you owe.

Step 2(b)—Multiple Jobs Worksheet *(Keep for your records.)*

If you choose the option in Step 2(b) on Form W-4, complete this worksheet (which calculates the total extra tax for all jobs) on **only ONE** Form W-4. Withholding will be most accurate if you complete the worksheet and enter the result on the Form W-4 for the highest paying job. To be accurate, submit a new Form W-4 for all other jobs if you have not updated your withholding since 2019.

Note: If more than one job has annual wages of more than $120,000 or there are more than three jobs, see Pub. 505 for additional tables; or, you can use the online withholding estimator at *www.irs.gov/W4App*.

1 **Two jobs.** If you have two jobs or you're married filing jointly and you and your spouse each have one job, find the amount from the appropriate table on page 4. Using the "Higher Paying Job" row and the "Lower Paying Job" column, find the value at the intersection of the two household salaries and enter that value on line 1. Then, **skip** to line 3 . . . . . **1** $

2 **Three jobs.** If you and/or your spouse have three jobs at the same time, complete lines 2a, 2b, and 2c below. Otherwise, skip to line 3.

a Find the amount from the appropriate table on page 4 using the annual wages from the highest paying job in the "Higher Paying Job" row and the annual wages for your next highest paying job in the "Lower Paying Job" column. Find the value at the intersection of the two household salaries and enter that value on line 2a . . . . . **2a** $

b Add the annual wages of the two highest paying jobs from line 2a together and use the total as the wages in the "Higher Paying Job" row and use the annual wages for your third job in the "Lower Paying Job" column to find the amount from the appropriate table on page 4 and enter this amount on line 2b . . . . . **2b** $

c Add the amounts from lines 2a and 2b and enter the result on line 2c . . . . . **2c** $

3 Enter the number of pay periods per year for the highest paying job. For example, if that job pays weekly, enter 52; if it pays every other week, enter 26; if it pays monthly, enter 12, etc. **3**

4 **Divide** the annual amount on line 1 or line 2c by the number of pay periods on line 3. Enter this amount here and in **Step 4(c)** of Form W-4 for the highest paying job (along with any other additional amount you want withheld) . . . . . **4** $

Step 4(b)—Deductions Worksheet *(Keep for your records.)*

1 Enter an estimate of your 2024 itemized deductions (from Schedule A (Form 1040)). Such deductions may include qualifying home mortgage interest, charitable contributions, state and local taxes (up to $10,000), and medical expenses in excess of 7.5% of your income . . . . . **1** $

2 Enter:
- $29,200 if you're married filing jointly or a qualifying surviving spouse
- $21,900 if you're head of household
- $14,600 if you're single or married filing separately

. . . . . **2** $

3 If line 1 is greater than line 2, subtract line 2 from line 1 and enter the result here. If line 2 is greater than line 1, enter "-0-" . . . . . **3** $

4 Enter an estimate of your student loan interest, deductible IRA contributions, and certain other adjustments (from Part II of Schedule 1 (Form 1040)). See Pub. 505 for more information . . . . **4** $

5 **Add** lines 3 and 4. Enter the result here and in **Step 4(b)** of Form W-4 . . . . . **5** $

Privacy Act and Paperwork Reduction Act Notice. We ask for the information on this form to carry out the Internal Revenue laws of the United States. Internal Revenue Code sections 3402(f)(2) and 6109 and their regulations require you to provide this information; your employer uses it to determine your federal income tax withholding. Failure to provide a properly completed form will result in your being treated as a single person with no other entries on the form; providing fraudulent information may subject you to penalties. Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation; to cities, states, the District of Columbia, and U.S. commonwealths and territories for use in administering their tax laws; and to the Department of Health and Human Services for use in the National Directory of New Hires. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

You are not required to provide the information requested on a form that is subject to the Paperwork Reduction Act unless the form displays a valid OMB control number. Books or records relating to a form or its instructions must be retained as long as their contents may become material in the administration of any Internal Revenue law. Generally, tax returns and return information are confidential, as required by Code section 6103.

The average time and expenses required to complete and file this form will vary depending on individual circumstances. For estimated averages, see the instructions for your income tax return.

If you have suggestions for making this form simpler, we would be happy to hear from you. See the instructions for your income tax return.

Married Filing Jointly or Qualifying Surviving Spouse

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	$0 - 9,999	$10,000 - 19,999	$20,000 - 29,999	$30,000 - 39,999	$40,000 - 49,999	$50,000 - 59,999	$60,000 - 69,999	$70,000 - 79,999	$80,000 - 89,999	$90,000 - 99,999	$100,000 - 109,999	$110,000 - 120,000
$0 - 9,999	$0	$0	$780	$850	$940	$1,020	$1,020	$1,020	$1,020	$1,020	$1,020	$1,370
$10,000 - 19,999	0	780	1,780	1,940	2,140	2,220	2,220	2,220	2,220	2,220	2,570	3,570
$20,000 - 29,999	780	1,780	2,870	3,140	3,340	3,420	3,420	3,420	3,420	3,770	4,770	5,770
$30,000 - 39,999	850	1,940	3,140	3,410	3,610	3,690	3,690	3,690	4,040	5,040	6,040	7,040
$40,000 - 49,999	940	2,140	3,340	3,610	3,810	3,890	3,890	4,240	5,240	6,240	7,240	8,240
$50,000 - 59,999	1,020	2,220	3,420	3,690	3,890	3,970	4,320	5,320	6,320	7,320	8,320	9,320
$60,000 - 69,999	1,020	2,220	3,420	3,690	3,890	4,320	5,320	6,320	7,320	8,320	9,320	10,320
$70,000 - 79,999	1,020	2,220	3,420	3,690	4,240	5,320	6,320	7,320	8,320	9,320	10,320	11,320
$80,000 - 99,999	1,020	2,220	3,620	4,890	6,090	7,170	8,170	9,170	10,170	11,170	12,170	13,170
$100,000 - 149,999	1,870	4,070	6,270	7,540	8,740	9,820	10,820	11,820	12,830	14,030	15,230	16,430
$150,000 - 239,999	1,960	4,360	6,760	8,230	9,630	10,910	12,110	13,310	14,510	15,710	16,910	18,110
$240,000 - 259,999	2,040	4,440	6,840	8,310	9,710	10,990	12,190	13,390	14,590	15,790	16,990	18,190
$260,000 - 279,999	2,040	4,440	6,840	8,310	9,710	10,990	12,190	13,390	14,590	15,790	16,990	18,190
$280,000 - 299,999	2,040	4,440	6,840	8,310	9,710	10,990	12,190	13,390	14,590	15,790	16,990	18,380
$300,000 - 319,999	2,040	4,440	6,840	8,310	9,710	10,990	12,190	13,390	14,590	15,980	17,980	19,980
$320,000 - 364,999	2,040	4,440	6,840	8,310	9,710	11,280	13,280	15,280	17,280	19,280	21,280	23,280
$365,000 - 524,999	2,720	6,010	9,510	12,080	14,580	16,950	19,250	21,550	23,850	26,150	28,450	30,750
$525,000 and over	3,140	6,840	10,540	13,310	16,010	18,590	21,090	23,590	26,090	28,590	31,090	33,590

Single or Married Filing Separately

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	$0 - 9,999	$10,000 - 19,999	$20,000 - 29,999	$30,000 - 39,999	$40,000 - 49,999	$50,000 - 59,999	$60,000 - 69,999	$70,000 - 79,999	$80,000 - 89,999	$90,000 - 99,999	$100,000 - 109,999	$110,000 - 120,000
$0 - 9,999	$240	$870	$1,020	$1,020	$1,020	$1,540	$1,870	$1,870	$1,870	$1,870	$1,910	$2,040
$10,000 - 19,999	870	1,680	1,830	1,830	2,350	3,350	3,680	3,680	3,680	3,720	3,920	4,050
$20,000 - 29,999	1,020	1,830	1,980	2,510	3,510	4,510	4,830	4,830	4,870	5,070	5,270	5,400
$30,000 - 39,999	1,020	1,830	2,510	3,510	4,510	5,510	5,830	5,870	6,070	6,270	6,470	6,600
$40,000 - 59,999	1,390	3,200	4,360	5,360	6,360	7,370	7,890	8,090	8,290	8,490	8,690	8,820
$60,000 - 79,999	1,870	3,680	4,830	5,840	7,040	8,240	8,770	8,970	9,170	9,370	9,570	9,700
$80,000 - 99,999	1,870	3,690	5,040	6,240	7,440	8,640	9,170	9,370	9,570	9,770	9,970	10,810
$100,000 - 124,999	2,040	4,050	5,400	6,600	7,800	9,000	9,530	9,730	10,180	11,180	12,180	13,120
$125,000 - 149,999	2,040	4,050	5,400	6,600	7,800	9,000	10,180	11,180	12,180	13,180	14,180	15,310
$150,000 - 174,999	2,040	4,050	5,400	6,860	8,860	10,860	12,180	13,180	14,230	15,530	16,830	18,060
$175,000 - 199,999	2,040	4,710	6,860	8,860	10,860	12,860	14,380	15,680	16,980	18,280	19,580	20,810
$200,000 - 249,999	2,720	5,610	8,060	10,360	12,660	14,960	16,590	17,890	19,190	20,490	21,790	23,020
$250,000 - 399,999	2,970	6,080	8,540	10,840	13,140	15,440	17,060	18,360	19,660	20,960	22,260	23,500
$400,000 - 449,999	2,970	6,080	8,540	10,840	13,140	15,440	17,060	18,360	19,660	20,960	22,260	23,500
$450,000 and over	3,140	6,450	9,110	11,610	14,110	16,610	18,430	19,930	21,430	22,930	24,430	25,870

Head of Household

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	$0 - 9,999	$10,000 - 19,999	$20,000 - 29,999	$30,000 - 39,999	$40,000 - 49,999	$50,000 - 59,999	$60,000 - 69,999	$70,000 - 79,999	$80,000 - 89,999	$90,000 - 99,999	$100,000 - 109,999	$110,000 - 120,000
$0 - 9,999	$0	$510	$850	$1,020	$1,020	$1,020	$1,020	$1,220	$1,870	$1,870	$1,870	$1,960
$10,000 - 19,999	510	1,510	2,020	2,220	2,220	2,220	2,420	3,420	4,070	4,070	4,160	4,360
$20,000 - 29,999	850	2,020	2,560	2,760	2,760	2,960	3,960	4,960	5,610	5,700	5,900	6,100
$30,000 - 39,999	1,020	2,220	2,760	2,960	3,160	4,160	5,160	6,160	6,900	7,100	7,300	7,500
$40,000 - 59,999	1,020	2,220	2,810	4,010	5,010	6,010	7,070	8,270	9,120	9,320	9,520	9,720
$60,000 - 79,999	1,070	3,270	4,810	6,010	7,070	8,270	9,470	10,670	11,520	11,720	11,920	12,120
$80,000 - 99,999	1,870	4,070	5,670	7,070	8,270	9,470	10,670	11,870	12,720	12,920	13,120	13,450
$100,000 - 124,999	2,020	4,420	6,160	7,560	8,760	9,960	11,160	12,360	13,210	13,880	14,880	15,880
$125,000 - 149,999	2,040	4,440	6,180	7,580	8,780	9,980	11,250	13,250	14,900	15,900	16,900	17,900
$150,000 - 174,999	2,040	4,440	6,180	7,580	9,250	11,250	13,250	15,250	16,900	18,030	19,330	20,630
$175,000 - 199,999	2,040	4,510	7,050	9,250	11,250	13,250	15,250	17,530	19,480	20,780	22,080	23,380
$200,000 - 249,999	2,720	5,920	8,620	11,120	13,420	15,720	18,020	20,320	22,270	23,570	24,870	26,170
$250,000 - 449,999	2,970	6,470	9,310	11,810	14,110	16,410	18,710	21,010	22,960	24,260	25,560	26,860
$450,000 and over	3,140	6,840	9,880	12,580	15,080	17,580	20,080	22,580	24,730	26,230	27,730	29,230

Chaffey College
Career Services

Most items listed below are included in this document for review only and do not need to be printed or submitted to the Student Employment Office. Only print, sign, and submit this Acknowledgement of Documentation sheet (page 1) to verify receipt/review of the documents and forms listed below.*

Acknowledgement of Documentation

Board Policies and Administrative Procedures

- Nondiscrimination BP 3410
- Prohibition of Harassment BP 3430
- Campus Safety BP 3500 & Workplace Violence BP 3510

Instructions for Completing Form I-9, Employment Eligibility Verification

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I, the undersigned, affirm that I have **1)** received/reviewed information on procedures and requirements regarding workers' compensation coverage, **2)** received an opportunity to designate a physician as provided in Labor Code, Section 4600 and **3)** received/reviewed the documents as listed above. I understand that I must read and become familiar with these documents and that it is my responsibility to ask for clarification when needed. I understand that participation in the student employment program requires a minimum cumulative GPA of 2.0 and enrollment in 6 or more units during fall and spring semesters.

_____
Student Employee Name (please print)

_____ _____
Signature Date

*__Exceptions__: To pre-designate a physician for treatment in the event of a work-related injury or illness, you must also print the **Personal Physician Pre-Designation** form (p. 7) and the **Certification of Personal Physician** form (p. 8). Minors (under age 18) must complete the **Certificate of Age** (p. 24-25).

Chaffey College
Office of Human Resources

TO: All Chaffey College Employees and Volunteers

DATE: July 5, 2018

FROM: Susan Hardie, Director, Human Resources

RE: Workers' Compensation Medical Provider Network (MPN)

California Law requires your employer to provide and pay for medical treatment if you are injured at work. Chaffey Community College District is pleased to provide this medical care through a Workers' Compensation Medical Provider Network (MPN). A Medical Provider Network is a group of health care providers set up by an employer and approved by California's Division of Workers' Compensation to treat workers injured on the job. The enclosed/attached pamphlet contains important information regarding the Medical Provider Network and your workers' compensation medical benefits. Please read it carefully.

Your medical treatment for a work-related injury or illness will be provided through the Medical Provider Network if your injury or illness occurs on or after July 1, 2006. You still have the option of treating with your personal physician (pursuant to Labor Code Section 4600) if you have properly notified Chaffey Community College District of your desire to treat with your personal physician prior to your injury or illness, and your personal physician agrees to treat you for your work-related injury or illness. If your personal physician is a participating provider then you are automatically covered by the MPN, unless your personal physician was pre-designated. If you already have a work-related injury or illness that occurred prior to the implementation of the Medical Provider Network and your treating physician is or becomes a participating physician then you are automatically covered, or, alternatively, you may request to have your treatment transferred to a participating physician.

For additional information, please review the enclosed/attached pamphlet. To obtain updates to the attached pamphlet on access standards, out-of-area medical treatment, the specialist referral process, and how to obtain a copy of your medical records, or to obtain a complete copy of the Employee Handbook, you may contact Patient Services Department directly via phone at (800) 544-8150, fax (888) 620-6921, or through the web-site: info@WellComp.com.

Welcome to WellComp

Your employer has elected to provide you with the choice of a broad scope of medical services for work-related injuries and illnesses by implementing a Medical Provider Network (MPN), called WellComp. WellComp delivers quality medical care through your choice of a provider who is part of an exclusive network of healthcare providers, each of whom possess a deep understanding of the California workers' compensation system and the impact their decisions have on you. Your employer has received the approval from the State of California to cover your workers' compensation medical care needs through the WellComp Network. You are automatically covered by the WellComp Network if your date of injury or illness is on or after your employer's MPN implementation date and if you have not properly pre-designated a personal physician prior to your injury or illness.

In the event that you have an injury or illness, you may carry this pamphlet with you to present to your medical service provider for access to care.

This pamphlet is not required to receive medical services

Initial Care

In case of an emergency, you should call 911 or go to the closest emergency room.

In the event that you experience a work-related injury or illness, immediately notify your supervisor and obtain medical authorization from your employer to designate an initial care provider within the network. If you are unable to reach your supervisor or employer, please contact the patient services department at WellComp. For non-emergency services, the MPN must ensure that you are provided an appointment for initial treatment within 3 business days of your employer's or MPN receipt of request for treatment within the MPN.

Access to Medical Care

Subsequent Care

If you still need treatment following your initial evaluation, you may be treated by a physician of your choice, or the initial physician may refer you to a medically and geographically appropriate specialist within the network who can provide the appropriate treatment for your injury or condition. Your employer is required to provide you with at least three physicians of each specialty expected to treat common injuries experienced by injured employees based on your occupation or industry. These physicians will be available within 30 minutes or 15 miles of your workplace or residence and specialists will be available within 60 minutes or 30 miles of your residence or workplace. For a directory of providers, please visit www.WellComp.com or call WellComp Patient Services.

Emergency Care

In an emergency, defined as a medical condition starting with the sudden onset of severe symptoms that without immediate medical attention could place your health in serious jeopardy, go to the nearest healthcare provider regardless of whether they are a WellComp participant. If your injury is work-related, advise your emergency care provider to contact WellComp to arrange for a transfer of your care to a WellComp provider at the medically appropriate time.

Hospital and Specialty Care

Your primary treating provider in the WellComp Network can make all of the necessary arrangements and referrals for specialists, inpatient hospital, outpatient surgery center services, and ancillary care services.

Choosing a Treating Physician

If you still require treatment after your initial evaluation with your employer's designated provider, you may access the WellComp Directory and select an appropriate physician of your choice who can provide the necessary treatment for your condition or illness. For assistance determining physician options, please contact the Medical Access Assistant in the WellComp Patient Services Department or discuss your options with your initial care provider.

Scheduling Appointments

If you are having difficulty scheduling an appointment with your initial provider or subsequent provider, please contact the Medical Access Assistant in the WellComp Patient Services Department or your Claims Examiner.

Changing Primary Treating Physician

If you find it necessary to change your treating physician and it is determined that you require ongoing medical care for your injury or illness, you may select a new physician from the WellComp Directory and schedule an appointment. Once your appointment is scheduled, immediately contact WellComp Patient Services who will then coordinate the transfer of your medical records to your new provider.

Obtaining a Specialist Referral

As long as you continue to require medical treatment for your injury or illness, there are alternatives for obtaining a referral to a specialist:

1. Your primary treating provider in the WellComp Network can make all of the necessary arrangements for referrals to a specialist. This referral will be made within the network or outside of the network if needed.
2. You may select an appropriate specialist by accessing the WellComp Directory.
3. You may contact your Medical Access Assistants in the WellComp Patient Services who can help coordinate necessary arrangements.

If your primary treating provider makes a referral to a type of specialist not included in the network, you may select a specialist from outside the network.

For non-emergency specialist services, the MPN must ensure that you are provided an appointment within 20 business days of your employer's or MPN receipt of a referral to a specialist within the MPN.

Continuity of Care

What if I am being treated by a WellComp doctor and the doctor leaves WellComp?

Your employer has a written "Continuity of Care" Policy that may allow you to continue treatment with your doctor if your doctor is no longer actively participating in WellComp.
If you are being treated for a work-related injury in the WellComp Network and your doctor no longer has a contract with WellComp, your doctor may be allowed to continue to treat you if your injury or illness meets one of the following conditions:

- **(Acute)** A medical condition that includes a sudden onset of symptoms that require prompt care and has a duration of less than 90 days.
- **(Serious or Chronic)** Your injury or illness is one that is serious and continues for at least 90 days without full cure or worsens and requires ongoing treatment. You may be allowed to be treated by your current treating doctor for up to one year, until a safe transfer of care can be made.
- **(Terminal)** You have an incurable illness or irreversible condition that is likely to cause death within one year or less.
- **(Pending Surgery)** You already have a surgery or other procedure that has been authorized by your employer or insurer that will occur within 180 days of the MPN contract termination date.

If any of the above conditions exist, WellComp may require your doctor to agree in writing to the same terms he or she agreed to when he or she was a provider in the WellComp Network. If the doctor does not, he or she may not be able to continue to treat you.

If the contract with your doctor was terminated or not renewed by WellComp for reasons relating to medical disciplinary cause or reason, fraud or criminal activity, you will not be allowed to complete treatment with that doctor. For a complete copy of the Continuity of Care policy in English or Spanish, please visit www.WellComp.com or call WellComp Patient Services.

Transfer of Ongoing Care

What if you are already being treated for a work-related injury before the WellComp Network begins?

Your employer has a "Transfer of Care" policy which describes what will happen if you are currently treating for a work-related injury with a physician who is not a member of the WellComp Network. If your current treating doctor is a member of WellComp, then you may continue to treat with this doctor and your treatment will be under WellComp. If your current treating physician is not a participating physician within WellComp and you have not yet been transferred into the MPN, your physician can make referrals to providers within or outside the MPN. Your current doctor may be allowed to become a member of WellComp.

You will not be transferred to a doctor in WellComp if your injury or illness meets any of the following conditions:

- **(Acute)** The treatment for your injury or illness will be completed in less than 90 days.
- **(Serious or Chronic)** Your injury or illness is one that is serious and continues without full cure or worsens over 90 days. You may be allowed to be treated by your current treating doctor for up to one year from the date of receipt of the notification that you have a serious chronic condition.
- **(Terminal)** You have an incurable illness or irreversible condition that is likely to cause death within one year or less. Treatment will be provided for the duration of the terminal illness.
- **(Pending Surgery)** You already have a surgery or other procedure that has been authorized by your employer or insurer that will occur within 180 days of the MPN effective date.
- For a complete copy of the Transfer of Care policy in English or Spanish, please visit www.WellComp.com or call WellComp Patient Services.

Care Transfer Disputes

Notice of determination, from the employer or claims examiner, shall be sent to the covered employee's address and a copy of the letter shall be sent to the covered employee's primary treating physician. The notification shall be written in English and Spanish and use layperson's terms to the maximum extent possible. If WellComp is going to transfer your care and you disagree, you may ask your treating doctor for a report that addresses whether you are in one of the categories listed above. Your treating physician shall provide a report to you within twenty calendar days of the request. If the treating physician fails to issue the report, then you will be required to select a new provider from within the MPN. If either WellComp or you do not agree with your treating doctor's report, this dispute will be resolved according to Labor Code Section 4062. You must notify WellComp Patient Services Department if you disagree with this report.

If your treating doctor agrees that your condition does not meet one of those listed above, the transfer of care will go forward while you continue to disagree with the decision. If your treating doctor believes that your condition does meet one of those listed above, you may continue to treat with him or her until the dispute is resolved.

Second Opinion, Third Opinion and Independent Medical Review Process:

If you disagree with your doctor or do not like your doctor for any reason, you may always choose another doctor in the MPN.

■ Obtaining Second and Third Opinions

If you disagree with the diagnosis or treatment plan determined by your treating physician or your second opinion physician, and would like a second or third opinion, you must take the following steps:

- ✓ Notify your claims examiner who will provide you with a regional area listing of physicians and/or specialists within the WellComp Network who have the recognized expertise to evaluate or treat your injury or condition.
- ✓ Select a physician or specialist from the list.
- ✓ Within 60 days of receiving the list, schedule an appointment with your selected physician or specialist from the list provided by your claims examiner. Should you fail to schedule an appointment within 60 days, your right to seek another opinion will be waived.
- ✓ Inform your claims examiner of your selection and the appointment date so that we can ensure your medical records can be forwarded in advance of your appointment date. You may also request a copy of your medical records.
- ✓ You will be provided information and a request form regarding the Independent Medical Review (IMR) process at the time you select a third opinion physician. Information about the IMR process can be found in the MPN Employee Handbook.

If the Second/Third opinion doctor feels that your injury is outside of the type of injury he or she normally treats, the doctor's office will notify your employer or insurer. You will get another list of MPN doctors or specialists so you can make another selection.

If the 2nd/3rd opinion doctor agrees with your need for a treatment or test, you may be allowed to receive that recommended treatment or test from a provider inside or outside the MPN, including the 2nd or 3rd opinion physician.

■ Obtaining an Independent Medical Review (IMR)

If you disagree with the diagnosis or treatment plan determined by the third opinion physician, you may file the completed MPN Independent Medical Review Application form with the Administrative Director of the Division of Workers' Compensation. You may contact your claims examiner or the WellComp Patient Services Department for information about the Independent Medical Review process and the form to request an Independent Medical Review.

If the second opinion, third opinion or IMR agrees with your treating doctor, you will need to continue to receive medical treatment with a network physician if MPN contains a physician who can provide the recommended treatment. If the IMR does not agree with your treating network physician, you will be allowed to receive that medical treatment from a provider either inside or outside of the WellComp Network.

Any physician chosen outside of the WellComp Network must be within reasonable geographic area. The treatment or diagnostic test is limited to the recommendation of the MPN/ IMR.

■ Treatment Outside of the Geographic Area

WellComp has providers throughout California. If a situation arises which takes you out of the coverage area, such as temporary work, travel for work, or living temporarily or permanently outside the MPN geographic service area, please contact the WellComp Patient Services Department, your claims examiner, or your primary treating provider, and they will provide you with a selection of at least 3 approved out-of-network providers from whom you can obtain treatment or get second and third opinions from the referred selection of physicians.

Covered Medical Services:

The following is a summary of Workers' Compensation medical services that are available to employees covered by the WellComp Network.

Primary treating and specialty services including consultations and referrals

Examples of primary treating or specialty providers include: general medical practitioners, chiropractors, dentists, orthopedists, surgeons, psychologists, internists, psychiatrists, cardiologists, neurologists.

Inpatient Hospital and Outpatient Surgery Center services

Examples of inpatient hospital and outpatient surgery center providers include: acute hospital services, general nursing care, operating room and related facilities, intensive care unit and services, diagnostic lab or x-ray services, necessary therapies.

Ancillary Care services

Examples of ancillary care providers include: diagnostic lab or x-ray services, physical medicine, occupational therapy, medical and surgical equipment, counseling, nursing, medically appropriate home care, medication.

Emergency services including outpatient and out-of area emergency care

WellComp Managed Care Services™

WellComp Provider Directory

For more information about the MPN including access to a roster of all treating physicians in the MPN, go to www.WellComp.com where you can search by medical specialty, zip code, physician or provider group. For website assistance or to access a hard copy of the regional area listing and/or an electronic copy of the complete WellComp directory, please contact WellComp (your employer's designated medical provider network administrator):

WellComp Information

For questions about the use of MPN's or complaints The MPN contact is: Gale Chmidling, MPN Manager (800)544-8150

WellComp has individuals available to answer questions, provide website assistance, and generate provider listings. Medical Access Assistants are available to assist with finding an MPN physicians of your choice, including scheduling and confirming physician appointments. Assistants are available 7am to 8pm Pacific Standard Time, Monday through Saturday at the contact information below:

WellComp
Patient Services Department
P.O. Box 59914
Riverside, CA 92517
Toll Free (800) 544-8150
fax: (888) 620-6921 or
e-mail: info@WellComp.com

Rev 12/14

WellComp Managed Care Services™

Employee Notification

This pamphlet contains important information on accessing the WellComp Medical Provider Network:

- ✓ Find out if you are covered
- ✓ Access medical care
- ✓ Learn about continuity of care
- ✓ Choose your own physician
- ✓ Transfer into the WellComp Network
- ✓ Contact WellComp

MPN Identification Number: _____

This pamphlet is available in Spanish. For a free copy, please contact WellComp Medical Provider Network.

Este folleto esta disponible en el Español. Para una copia gratis, favor de llamar a WellComp Medical Provider Network

Pre-designation Of Personal Physician

In the event you sustain an injury or illness related to your employment, you may be treated for such injury/illness by your personal medical doctor (M.D) or doctor of osteopathic medicine (D.O.) or medical group if: You have health care insurance for injuries/illness that are not work related, the doctor is your regular physician, who shall be either a physician who has limited his or her practice of medicine to general practice or who is a board-certified or board-eligible internist, pediatrician, obstetrician-gynecologist, or family practitioner, and has previously directed your medical treatment, and retains your medical records; your "personal physician" may be a medical group if it is a single corporation or partnership composed of licensed doctors of medicine or osteopathy, which operates an integrated multispecialty medical group providing comprehensive medical services predominantly for non-occupational illnesses and injuries; prior to the injury your doctor agrees to treat you for work injuries or illnesses; prior to the injury you provided your employer the following in writing: (1) notice that you want your personal doctor to treat you for a work-related injury/illness, and (2) your personal doctor's name and business address.

You may use this form, a form provided by your employer or provide all the information in writing to notify your employer if you wish to have your personal medical doctor or a doctor osteopathic medicine treat you for a work-related injury/illness and the above requirements are met.

Notice Of Pre-designation Of Personal Physician

Employee: Complete this section

Employer _____

If I have a work-related injury or illness, I choose to be treated by:

_____
(Name of doctor) (M.D., D.O., or medical group)

_____
(street address, city, state, zip)

_____
(telephone number)

Employee Name (please print): _____

Employee's Address:_____

Employee Signature:_____Date_____

Note to Employee: Unless you agree in writing, neither your employer or York may contact your personal physician to confirm a pre-designation. If your physician does not sign this form, other documentation that they agreed to be pre-designated prior to the injury will be required. If you agree, your employer or York may contact your personal physician to confirm this pre-designation, sign and date below:

Employee Signature_____

Employee #_____ Date_____

Physician: I agree to this Pre-designation:

Signature:_____Date_____

(Physician or Designated Employee of the Physician)

The physician is not required to sign this form, however, if the physician or designated employee of the physician or medical group does not sign, other documentation of the physician's agreement to be pre-designated will be required pursuant to Title 8, California Code of Regulations, section 9780.1(a)(3).

Notice Of Personal Chiropractic Or Personal Acupuncturist

If your employer or your employer's insurer does not have a Medical Provider Network (MPN), you may be able to change your treating physician to your personal chiropractor (D.C.) or acupuncturist (L.AC.) following a work-related injury/illness. In order to be eligible to make this change, you must give your employer the name and business address of a personal D.C. or L.AC. in writing prior to the injury/illness. York generally has the right to select your treating physician within the first 30 days after your employer knows of your injury/illness. After your employer or York has initiated your treatment with another physician during this period, you may then, upon request, have your treatment transferred to your personal D.C. or L.AC. You may use this form to notify your employer of your personal D.C. or L.AC., or your employer may have their own form. The D.C. or L.AC. must be your regular D.C. or L.AC. who has directed your treatment and retains your chiropractic records and history. If your employer has an MPN, you may only switch to a D.C. or L.AC. within the MPN. A chiropractor cannot be your treating physician after 24 visits. If you still require medical treatment thereafter, you will have to select a physician who is not a chiropractor.

_____ _____
Name of chiropractor or acupuncturist (D.C., L.AC.)

_____
(street address, city, state, zip code)

_____
(telephone number)

Employee Name (Please Print):_____

Employee's Address:_____

_____

Employee's Signature:_____

Date:_____

WHEN A WORK INJURY OCCURS…

- **Quickly seek first aid.**
- **Call 9-1-1 for help immediately if emergency medical care is needed.**
- **Immediately report injuries to your supervisor or employer representative at** _____

Company Nurse on Call at 888-375-0280 with supervisor present.

Information & Assistance Office: Susan Hardie, Interim Director, Human Resources & Risk Management at 909-652-6531.

_____

Employer MUST complete this information

The Facts About Workers' Compensation

For dates of injury on or after January 1, 2013

York Risk Services Group, Inc.
P.O. Box 619079
Roseville, CA 95661
Phone (866) 221-2402
Fax (866) 548-2637

Approved by Division of Workers' Compensation

What is workers' compensation? Its purpose is to insure that an employee who is found to sustain an industrial injury or illness will be provided with benefits to medically cure or relieve them from the effects of the injury/illness, provide temporary compensation when they are medically unable to perform any occupational function, compensation for any residual handicap and/or impairment of bodily function, benefits for dependents if an employee dies as a result of an injury/illness, protection from discrimination by his/her employer because of the injury/illness.

Am I Covered? Nearly every person employed in California is protected by workers' compensation, however there are a few exceptions. People that are self-employed or volunteer workers may not be covered. Similar laws cover federal and maritime workers. York Risk Services Group (York) is your employer's claims administrator. Your employer or York can answer any questions you might have about coverage.

What Does Workers' Compensation Cover? If you have an injury/illness due to your job, it is covered. The cause can be a single event, like a fall or it can be due to repeated exposures, such as hearing loss due to constant loud noise. Injuries ranging from first-aid to serious accidents are covered. Even injuries related to a workplace crime, such as psychological or physical injuries, are covered under workers' compensation. Some injuries that result from voluntary activity, such as off duty social or athletic activities may not be covered. Check with your employer or York if you have questions. Coverage begins the moment you start your job. There is no probationary period or wage rate.

Duty Of The Employee. Immediately notify your employer or York so you can get the medical help that you need without delay. If your injury is greater than a first-aid injury, your supervisor will give you a Claim Form (Form DWC-1) for you to describe where, when and how it happened. To submit a claim, fill out the "Employee" section of the DWC-1. Keep one copy of this form and give the remaining pages to your supervisor. Your employer will fill out the "Employer" section and return a signed and dated copy of the form to you. Your employer will keep a copy of this form and forward another to York. York is in charge of handling your claim and informing you about your eligibility for benefits.

Your claim benefits do not start until your employer knows about your injury, so report and file the DWC-1 as quickly as possible. California law requires your employer to authorize medical treatment within one working day of receipt of your Claim Form. Employers are liable for up to $10,000 in treatment pending a decision by York for a claim to be accepted or rejected. Waiting to report may delay workers' compensation benefits. You may not receive benefits if you fail to file a claim within one year of the date of injury, the date you know the injury was work related, or the date benefits were last provided.

Duty of the Employer: Provide this form to every employee at the time of hire or by the end of their first pay period.

Within one working day, upon knowledge or notice from any source of a work injury/illness greater than first-aid, provide the employee with a Claim Form (DWC-1) and authorize medical treatment and report the claim to York Risk Services Group.

What are the benefits? You may be entitled to various kinds of benefits under California workers' compensation law including:

Medical Care: Medical treatment that is reasonably required to cure or relieve the injured worker from the effects of the injury/illness. There is no deductible or co-payment. These medical benefits may include lab tests, physical therapy, hospital services, medication and treatment by a doctor.

State law limits certain medical services as of January 1, 2004. You should never receive a medical bill. If additional treatment is necessary, York will coordinate medical care that meets applicable treatment guidelines for the injury. The doctor may be a specialist for your specific type of injury, and he or she will be familiar with workers' compensation requirements and will report promptly to York so your benefits can be paid.

The physician with overall responsibility for treating your injury/illness is your primary treating physician (PTP). The PTP decides what kind of medical care you need and if you have work restrictions. If necessary, the PTP will review your job description with you and your employer to define any limitation or restrictions that you may have. This doctor also is responsible for coordinating care between other medical providers and will write reports about any permanent impairment of bodily function(s) or the need for future medical care. Generally, your employer selects the PTP you will see for the first 30 days, but if you want to change doctors for any reason, ask your employer or York. They're as interested as you are in your prompt recovery and return to work and will select a different doctor for you. If your employer has a Medical Provider Network (MPN) you will be directed to treat with a physician within the MPN and different rules apply regarding changing your physician.

You can be treated by your personal physician or medical group immediately if you have health care insurance for injuries or illness that are not work related, and your physician agrees in advance to treat you for any work injuries/illnesses and has previously directed your treatment and retains your medical records and agrees, prior to your injury/illness, to treat you for workplace injuries/illnesses and you gave your employer your physician's name and address in writing before the injury. You may use the form inside of this pamphlet or your employer may have a form for you to use.

If you give the name of your personal chiropractor or acupuncturist, different rules apply, and you may need to see an employer-selected physician first.

Temporary Disability Benefits: If you are not medically able to work for more than three days due to your work-related injury, counting weekends, you have a right to temporary disability (TD) payments to assist substituting your lost wages. After two weeks from reporting the injury, you will receive a check. If your employer has a salary continuation plan, your benefit may be included in your regular paycheck. TD is payable every 14 days until the doctor states you can return to work (Payments won't be made for the first three days, though, unless you're hospitalized as an inpatient or unable to work more than 14 days). The amount of the payments will be two-thirds of your average wage, subject to minimums and maximums set by the state legislature. Although the TD payment will not be the full amount of your regular paycheck, there are no deductions and the payments are tax-free. For injuries occurring on or after January 1, 2008, TD payments are limited to 104 compensable weeks within five years of date of injury. For a few long-term injuries such as chronic lung disease or severe burns, TD payments can last up to 240 weeks within five years from the date of injury. If you reach the maximum TD payment period before you can return to work or before your condition becomes permanent and stationary. See the "Other Benefits" section of this pamphlet for additional in information. A timely filing with Employment Development Department may result in additional State Disability benefits when TD benefits are delayed, denied, or terminated.

Permanent Disability: If your doctor says your injury will always leave you with some permanent impairment of bodily function(s), you may receive permanent disability (PD) payments. The amount depends on the doctor's report, how much of the PD was directly caused by your work, and factors such as your age, occupation, type of injury, and date of injury. State law determines minimum and maximum amounts, and they vary by injury date. If you are entitled to PD, York will send you a letter explaining how the benefit was calculated. If the injury causes PD, the first payment of PD benefits is made within 14 days after the last payment of TD, unless your employer has offered you a position that pays at least 85% of your date of injury wages or if you are returned to a position that pays you 100% of the wages and, compensation paid to you on the date of injury, the PD would be paid after an Award issues.

Supplemental Job Displacement Benefit (SJDB): If you have a permanent whole person impairment, the eligibility for SJDB begins when your employer does not offer regular work, permanent, modified, or alternative work within 60 days of the receipt of a doctor's Medical Maximum Improvement (MMI) report. This is a nontransferable voucher for education-related retraining and/or skill development at state-approved schools, tools, licensing, certification fees and other resources as possible benefits. If you qualify for the supplemental job displacement benefit, York will provide a voucher up to a maximum of $6,000.

Death Benefits: If the injury/illness causes death, payments may be made to your dependents. State law sets these benefits and the total benefit depends on the number of dependents. The payments are made at the same rate as TD payments. In addition, workers' compensation provides a burial allowance.

Discrimination: It a violation of Labor Code Section 132(a) and illegal for your employer to punish or fire you for having a workplace injury/illness, for filing a claim or for testifying in another person's workers' compensation case. If your employer is found guilty of discrimination, you would be entitled to increased benefits, reinstatement and reimbursement for lost wages and benefits.

Other Benefits: Sometimes people confuse workers' compensation with State Disability Insurance (SDI). Workers' compensation covers on-the-job injuries/ illnesses and is paid for by your employer or their insurance. On the other hand, SDI covers off-the-job injuries or sicknesses, and is paid for by deductions from your paycheck. If you are not getting workers' compensation benefits, you may be able to get State Disability benefits. Contact the local office of the State Employment Development Department listed in the government pages of your phone book for more information.

You may be eligible to access the return-to-work fund, for the purposes of making supplemental payments to injured worker's whose PD benefits are disproportionately low in comparison to their earnings loss. If you have questions or think you qualify, contact the Information & Assistance office listed in this pamphlet or visit the DIR website at: www.dir.ca.gov.

If You Still Have Questions…ask your supervisor or employer representative. Or contact York at the number indicated on workers' compensation posters at work and on this brochure. You can also contact the State Division of Workers' Compensation (DWC) and speak with an Information and Assistance Officer. These officers are available to review problems, answer questions and provide additional written information about workers' compensation at no charge. The local office is listed below and posted at your workplace. You can also call 800-736-7401 or visit the DWC website at: http://www.dir.ca.gov/dwc.

WORKERS' COMPENSATION FRAUD IS A FELONY

Anyone who makes or causes to be made any knowingly false or fraudulent material statement for the purpose of obtaining or denying workers' compensation benefits or payments is guilty of a felony. Fines can be up to $150,000 and imprisonment up to five years.

Chaffey College

OPTIONAL

PERSONAL PHYSICIAN PRE-DESIGNATION

Date employee was provided Pre-Designation form: _____

Employee:_____

Department:_____

Pursuant to Labor Code 4600(d), the definition of "Personal Physician" means:

- ✓ The employee's regular physician and surgeon,
- ✓ Who, prior to the injury, has directed medical treatment of the employee, and
- ✓ Retains the medical records and medical history of the employee.

Name of Physician:_____

Specialty:_____

Address/City/Zip Code:_____

Telephone:_____ Fax #:_____

Employee Name (print):_____

Employee Signature:_____

Date of Request:_____

If this form and the attached Certification is not completed and returned to your Employer prior to an industrial injury, the employee is to seek medical treatment from the Employer-designated medical facility as noted on the posted notices regarding workers' compensation.

Your personal physician is required to adhere to Title 8, California Code of Regulations 9785, the Reporting Duties of the Primary Treating Physician and Labor Code 4610. Your personal physician *must agree* to be your pre-designated physician and that they will accept payment for service in accordance with the California Official Medical Fee Schedule.

Please have your personal physician sign and return this form to your Employer with the attached Certification acknowledging their responsibility as your treating physician should you sustain an industrial injury.

Submit form to the office of Human Resources

Chaffey College

OPTIONAL

CERTIFICATION OF PERSONAL PHYSICIAN

Date:_____

Name of Physician:_____

Address:_____

City/Zip Code:_____

Name of Employee:_____

This is to certify that _____(employee) is a patient of mine. I have treated him/her for non-work related medical problems and I maintain his/her medical records in my office.

I am willing to take responsibility for following rules required of a Treating Physician, pursuant to California Code of Regulations, Title 8, Section 9785, when treating this employee for work-related injuries or illnesses. I acknowledge all requests for medical care will be governed by Labor Code 4610 outlining mandatory utilization review under the guidelines of the American College of Occupational and Environmental Medicine (ACOEM).

Physician's Signature:_____

Print Name:_____

Date:_____

I decline the request of _____(employee) to be his/her Treating Physician for work-related injuries:

Physician's Signature:_____

Print Name:_____

Date:_____

Submit form to the office of Human Resources

April 15, 2005

THIS POSTER MUST BE DISPLAYED WHERE EMPLOYEES CAN EASILY READ IT

(Poster may be printed on 8 ½" x 11" letter size paper)

HEALTHY WORKPLACES/HEALTHY FAMILIES ACT: CALIFORNIA PAID SICK LEAVE

(as amended effective 1/1/2024)

Entitlement:

- An employee who, on or after July 1, 2015, works in California for 30 or more days within a year from the beginning of employment is entitled to paid sick leave.
- Paid sick leave accrues at the rate of one hour per every 30 hours worked, paid at the employee's regular wage rate. Accrual shall begin on the first day of employment or July 1, 2015, whichever is later. Accrued paid sick leave shall carry over to the following year of employment and may be capped at 80 hours or 10 days.
- An employer can also provide 5 days or 40 hours, whichever is greater, of paid sick leave "up-front" at the beginning of a 12-month period. No accrual or carry over is required.
- Other accrual plans that meet specified conditions, including PTO plans, may also satisfy the requirements.

Usage:

- An employee may use paid sick days beginning on the 90th day of employment.
- An employer shall provide paid sick days upon the oral or written request of an employee for themselves or a family member for the diagnosis, care or treatment of an existing health condition or preventive care, or specified purposes for an employee who is a victim of domestic violence, sexual assault, or stalking.
- An employer may limit the use of paid sick days to 40 hours or five days, whichever is greater, in each year of employment.

Retaliation or discrimination against an employee who requests paid sick days or uses paid sick days or both is prohibited. An employee can file a complaint with the Labor Commissioner against an employer who retaliates or discriminates against the employee.

For additional information you may contact your employer or the local office of the Labor Commissioner. Locate the office by looking at the list of offices on our website http://www.dir.ca.gov/dlse/DistrictOffices.htm using the alphabetical listing of cities, locations, and communities. Staff is available in person and by telephone.

Enroll now for Electronic W2 & Direct Deposit

Benefits of Electronic W2:

- Receive your W2 **earlier** than traditional paper W2s
- Eliminate the risk that your W2 will be lost, misdirected or delayed during the mail distribution process
- Access your W2 at your convenience 24-7 from any computer that has internet access. The W2s are stored securely on MyChaffeyView and employees can view, print or re-print at a later date.

To receive your W2 form electronically via MyChaffeyView you must provide consent. Simply log into MyChaffeyView to review the disclosure statement and provide your consent. If you need assistance logging into MyChaffeyView there is a login and password help link on the main MyChaffeyView menu.

Benefits of Direct Deposit:

- Eliminate the worry of having to pick up your check, especially if you're not on campus or out of town.
- If you chose to have your check mailed it stands the chance of getting lost, stolen, destroyed or delayed in the mail.
- The process to replace a check can take up to 3 days.
- With Direct Deposit, your money is electronically transferred into your account and available to you the morning of the release date.
- You have the ability to split your Direct Deposit among different accounts and/or different banks.
- If the release date of your payroll falls on a day when the campus is closed you will have to wait until the next college business day to pick up your check. This may occur during our summer schedule when the campus is closed on Fridays. If your pay date falls on a Friday, you will have to wait until Monday to pick up your check.

Please call the Payroll Department if you need assistance:

Maria Jara—Classified Payroll: (909) 652-6029

Tara Schroeder—Certificated Payroll: (909) 652-6037

Kim Mascarenas—Administrator, Payroll: (909) 652-6030

CHAFFEY COLLEGE

Chaffey Community College

403(b) Tax Shelter Annuity

Retirement Savings for your Future!

PARTICIPATION ELIGIBILITY

ALL Chaffey employees are eligible to participate in the District's 403(b) Tax Shelter Annuity Plan.

To participate, please complete a salary reduction agreement (SRA) and establish your retirement investment account with one of our approved 403(b) vendors. Since these contributions are deducted from your monthly compensation, please make sure that your deduction **does not** exceed your monthly salary. This especially applies to part-time employees whose hours and salary fluctuate from month to month.

CONTRIBUTION TYPES

- Basic Annual Contribution
- Catch-up Contribution, if worked for more than 15 years with Chaffey *
- Catch-up Contribution, if age 50 and older
- Rollovers, Transfers, and Exchanges are permitted

* Subject to a calculation to determine eligibility

Chaffey Community College

College Contacts:

Director of Accounting
Myriam Arellano
Ext. 6177

Classified Payroll
Maria Jara
Ext. 6029

Certificated Payroll
Tara Schroeder
Ext. 6037

Payroll Administrator
Kim Streit
Ext. 6030

STATE OF CALIFORNIA DEPARTMENT OF EDUCATION

STATEMENT OF INTENT TO EMPLOY A MINOR AND REQUEST FOR A WORK PERMIT–CERTIFICATE OF AGE

CDE Form B1-1 (Rev. 02-14)

A "STATEMENT OF INTENT TO EMPLOY A MINOR AND REQUEST FOR A WORK PERMIT–CERTIFICATE OF AGE" form (CDE Form B1-1) shall be completed in accordance with California *Education Code* 49162 and 49163 as notification of intent to employ a minor. This form is also a Certificate of Age pursuant to California *Education Code* 49114.

(Print Information)

Minor's Information

Minor's Name *(First and Last)* | Home Phone | Grade

Home Address | City | Zip Code

Birth Date | Social Security Number | Age | Student's Signature

School Information

Chaffey College — School Name
(909) 652-6000 — School Phone
5885 Haven Ave. — School Address
Rancho Cucamonga — City
91737 — Zip Code

To be filled in and signed by parent or legal guardian

This minor is being employed at the place of work described with my full knowledge and consent. I hereby certify that to the best of my knowledge and belief, the information herein is correct and true.

Parent's Name (*Print First and Last*) | Parent's Signature | Date

To be filled in and signed by employer

Chaffey Community College — Business Name or Agency of Placement
(909) 652-6000 — Business Phone
Supervisor's Name
5885 Haven Ave. — Business Address
Rancho Cucamonga — City
91737 — Zip Code

Employer's Maximum Expected Work Hours: _____ hours per day _____ hours per week

Describe nature of work to be performed: Employee will perform the supervised work of a student assistant in support of the hiring department to receive on-campus general work experience; the nature of the work is not considered hazardous.

In compliance with California labor laws, this employee is covered by workers' compensation insurance. This business does not discriminate unlawfully on the basis of race, ethnic background, religion, sex, sexual orientation, color, national origin, ancestry, age, physical handicap, or medical condition. I hereby certify that, to the best of my knowledge, the information herein is correct and true.

Employer's Name *(Print First and Last)* | Employer's Signature | Date

For authorized work permit issuer use ONLY

Maximum number of work hours when school is in session:

Mon	Tues	Wed	Thur	Fri	Sat	Sun	Total

Maximum number of work hours when school is not in session:

Mon	Tues	Wed	Thur	Fri	Sat	Sun	Total

Proof of Minor's Age *(Evidence Type)*

Verifying Authority's Name and Title *(Print)*

Verifying Authority's Signature

Check Permit Type:

- ☐ Full-time
- ☐ Restricted
- ☐ General
- ☐ Work Experience Education, Vocational Education, or Personal Attendant
- ☐ Workability

For more information about child labor laws, contact the U.S. Department of Labor at http://www.dol.gov/, and the State of California Department of Industrial Relations, Division of Labor Standards Enforcement at http://www.dir.ca.gov/DLSE/dlse.html.

STATE OF CALIFORNIA DEPARTMENT OF EDUCATION

STATEMENT OF INTENT TO EMPLOY A MINOR AND REQUEST FOR WORK PERMIT—CERTIFICATE OF AGE

CDE B1-1 (Rev. 07-10)

General Summary of Minors' Work Regulations

FLSA-Federal Labor Standards Act, CDE-California Department of Education, *EC*-California *Education Code*, *LC*-California *Labor Code, CFR*-California Federal Regulations

- **If federal laws, state laws, and school district policies conflict, the more restrictive law (the one most protective of the minor) prevails. (FLSA)**
- Employers of minors required to attend school must complete a "Statement of Intent to Employ a Minor and Request for Work Permit" (CDE B1-1) for the school attendance for each such minor. (*EC* 49162)
- Employers must retain a "Permit to Employ and Work" (CDE B1-4) for each such minor. (*EC* 49161)
- Work permits (CDE B1-4) must be retained for three years and be available for inspection by sanctioned authorities at all times. (*EC* 49164)
- A work permit (CDE B1-4) must be revoked whenever the issuing authority determines the employment is illegal or is impairing the health or education of the minor. (*EC* 49164)
- A day of rest from work is required in every seven days, and shall not exceed six days in seven. (*LC* 551, 552)

Minors under the age of 18 may not work in environments declared hazardous or dangerous for young workers, examples listed below: (*LC* 1294.1 and 1294.5, 29 *CFR* 570 Subpart E)

1. Explosive exposure
2. Motor vehicle driving/outside helper
3. Roofing
4. Logging and sawmilling
5. Power-driven woodworking machines
6. Radiation exposure
7. Power-driven hoists/forklifts
8. Power-driven metal forming, punching, and shearing machines
9. Power saws and shears
10. Power-driving meat slicing/processing machines

HOURS OF WORK

16 & 17 Year Olds	14 & 15 Year Olds	12 & 13 Year Olds
Must have completed 7th grade to work while school is in session. (*EC* 49112)	Must have completed 7th grade to work while school is in session (*EC* 49112)	Labor laws generally prohibit non-farm employment of children younger than 14. Special rules apply to agricultural work, domestic work, and the entertainment industry. (*LC* 1285–1312)
School In Session		
4 hours per day on any schoolday (*EC* 49112; 49116; *LC* 1391) 8 hours on any non-schoolday or on any day preceding a non-schoolday. (*EC* 49112; *LC* 1391) 48 hours per week (*LC* 1391) WEE students & personal attendants may work more than 4 hours on a schoolday, but never more than 8. (*EC* 49116; *LC* 1391, 1392)	3 hours per schoolday outside of school hours (*EC* 49112, 49116; *LC* 1391) 8 hours on any non-schoolday No more than 18 hours per week (*EC* 49116; *LC* 1391) WEE students may work during school hours & up to 23 hours per week. (*EC* 49116; *LC* 1391)	2 hours per schoolday and a maximum of 4 hours per week. (*EC* 49112)
School Not In Session		
8 hours per day (*LC* 1391, 1392) 48 hours per week (*LC* 1391)	8 hours per day (*LC* 1391, 1392) 40 hours per week (*LC* 1391)	8 hours per day (*LC* 1391, 1392) 40 hours per week (*LC* 1391)
Spread of Hours		
5 a.m.–10 p.m. However, until 12:30 a.m. on any evening preceding a non-schoolday (*LC* 1391) WEE students, with permission, until 12:30 a.m. on any day (*LC* 1391.1) Messengers: 6 a.m.–9 p.m.	7 a.m.–7 p.m., except that from June 1 through Labor Day, until 9 p.m. (*LC* 1391)	7 a.m.–7 p.m., except that from June 1 through Labor Day, until 9 p.m. (*LC* 1391)

For more information about child labor laws, contact the U.S. Department of Labor at http://www.dol.gov/, and the State of California Department of Industrial Relations, Division of Labor Standards Enforcement at http://www.dir.ca.gov/DLSE/dlse.html.

Notice 1392

(Rev. January 2020)

Department of the Treasury
Internal Revenue Service

Supplemental Form W-4 Instructions for Nonresident Aliens

Nonresident aliens must follow special instructions when completing Form W-4, Employee's Withholding Certificate, for compensation paid to such individuals as employees performing dependent personal services in the United States. Compensation for dependent personal services includes amounts paid as wages, salaries, fees, bonuses, commissions, compensatory scholarships, fellowship income, and similar designations for amounts paid to an employee.

Getting tax forms and publications. Go to *IRS.gov/Forms-Instructions* to view, download, or print all of the forms and publications you may need. You can also download and view popular tax publications and instructions on mobile devices as an eBook at no charge. Or, you can go to *IRS.gov/OrderForms* to place an order and have forms mailed to you within 10 business days. Also, you can call 800-829-3676 to place your order.

Are you a nonresident alien? If so, these special instructions apply to you. Resident aliens should follow the instructions on Form W-4.

If you are an alien individual (that is, an individual who is not a U.S. citizen), specific rules apply to determine if you are a resident alien or a nonresident alien for federal income tax purposes. Generally, you are a resident alien if you meet either the “green card test,” or the “substantial presence test,” for the calendar year. Any alien individual not meeting either test is generally a nonresident alien. Additionally, a dual-resident alien who applies the so-called “tie-breaker” rules contained within the Resident (or Residence or Fiscal Residence) article of an applicable U.S. income tax treaty in favor of the other Contracting State is treated as a nonresident alien. See Pub. 519, U.S. Tax Guide for Aliens, for more information on the green card test, the substantial presence test, and the first-year choice.

What compensation is subject to withholding and requires a Form W-4?

Compensation paid to a nonresident alien for performing personal services as an employee in the United States is subject to graduated withholding. Compensation for personal services also includes amounts paid as a scholarship or fellowship grant to the extent it represents payment for past, present, or future services performed as an employee in the United States. Nonresident aliens must complete Form W-4 using the modified instructions provided later, so that employers can withhold the correct amount of federal income tax from compensation paid for personal services performed in the United States. This Notice modifies the instructions to Form W-4 to take into account the restriction on a nonresident alien's filing status, the restriction on claiming the standard deduction, and the restriction on claiming tax credits and deductions for certain Nonresident aliens.

Are there any exceptions to this withholding?

Yes. Nonresident aliens may be exempt from wage withholding on the following amounts.

- Compensation paid to employees of foreign employers if such pay is not more than $3,000 and the employee is temporarily present in the United States for not more than a total of 90 days during the tax year.
- Compensation paid to regular crew members of a foreign vessel.
- Compensation paid to residents of Canada or Mexico engaged in transportation-related employment.
- Certain compensation paid to residents of American Samoa, Puerto Rico, or the U.S. Virgin Islands.
- Compensation paid to foreign agricultural workers temporarily admitted into the United States on H-2A visas.

See Pub. 519 to see if you qualify for one of these exemptions.

Nonresident aliens may be exempt from wage withholding on part or all of their compensation for dependent personal services under an income tax treaty. If you are claiming a tax treaty withholding exemption, do not complete Form W-4. Instead, complete Form 8233, Exemption from Withholding on Compensation for Independent (and Certain Dependent) Personal Services of a Nonresident Alien Individual, and give it to each withholding agent from whom amounts will be received.

Even if you submit Form 8233, the withholding agent may have to withhold tax from your income because the factors on which the treaty exemption is based may not be determinable until after the close of the tax year. In this case, you must file Form 1040-NR, U.S. Nonresident Alien Income Tax Return (or Form 1040-NR-EZ, U.S. Income Tax Return for Certain Nonresident Aliens With No Dependents, if you qualify), to recover any overwithheld tax and to provide the IRS with proof that you are entitled to the treaty exemption. See Form 8233 and the Instructions for Form 8233, Pub. 901, U.S. Tax Treaties, and Pub. 519 for more information on treaty benefits.

Am I required to file a U.S. tax return even if I am a nonresident alien?

Yes. Nonresident aliens who perform personal services in the United States are considered to be engaged in a trade or business in the United States and generally are required to file Form 1040-NR (or Form 1040-NR-EZ). Also, you will need to file Form 1040-NR (or Form 1040-NR-EZ) to claim a refund of any overwithheld taxes. See the Instructions for Form 1040-NR, or the Instructions for Form 1040-NR-EZ, for more information.

Nonresident aliens who are bona fide residents of U.S. possessions should consult Pub. 570, for information on whether compensation is subject to wage withholding in the United States.

Will my withholding amounts be different from withholding for my U.S. coworkers?

Yes. Nonresident aliens cannot claim the standard deduction. The benefits of the standard deduction are included in the existing wage withholding tables published in Pub. 15-T, Federal Income Tax Withholding Methods.

Because nonresident aliens may not claim the standard deduction, employers are instructed to withhold an additional amount from a nonresident alien's wages. For the specific amounts to be added to wages before application of the wage tables, see Pub. 15-T.

Note. A special rule applies to nonresident alien students from India and business apprentices from India who are eligible for the benefits of Article 21(2) of the United States-India income tax treaty. Employers are not required to withhold an additional amount for the standard deduction from the wages of these individuals, as they may be entitled to claim the standard deduction. See Pub. 15-T and Pub. 519 for more information.

What are the special Form W-4 instructions?

Nonresident aliens should pay particular attention to the following lines when completing Form W-4.

Step 1(b): Personal Information. You are required to enter a social security number (SSN) on Step 1(b) of Form W-4. If you do not have an SSN, contact the Social Security Administration (SSA) to find out if you are eligible for one.

You can visit any SSA office or call the SSA at 800-772-1213. For the deaf or hard-of-hearing, call 800-325-0778 (TTY/TTD number).

For more information, go to *www.ssa.gov/ssnumber*.

Note. You cannot enter an individual taxpayer identification number (ITIN) in Step 1(b) of Form W-4.

Step 1(c): Personal Information. Check the Single or Married filing separately box regardless of your actual marital status.

Step 2: Multiple Jobs or Spouse Works. Do not complete this section unless you have more than one job at the same time. Do not account for your spouse's job because nonresident aliens may not file jointly.

If you have more than one job, you may complete Step 2(b) or Step 2(c).

If you chose Step 2(b), complete the Step 2(b) Multiple Jobs Worksheet for **only one** job and write "nonresident alien" or "NRA" below Step 4(c) for **only one** job.

If you have only two jobs, you may choose Step 2(c), check the box on **both** Forms W-4, and write "NRA" or "nonresident alien" below Step 4(c) for the Form W-4 for the highest paying job. Do not write "nonresident alien" or "NRA" below Step 4(c) for the other job.

Nonresident aliens should not use the Tax Withholding Estimator.

Multiple withholding agents. If you are completing Form W-4 for more than one withholding agent (for example, you have more than one employer), complete Steps 3-4(b) on only one Form W-4. Withholding will be most accurate if you do this on the Form W-4 for the highest paying job.

Step 3: Claim Dependents. Only certain nonresident aliens should use Step 3. Nonresident aliens from Canada, Mexico, South Korea, or India may be able to claim the child tax credit or the credit for other dependents. See Pub. 519 and Pub. 972 for more information.

Nonresident aliens are generally not entitled to education credits. See Pub. 519 for more information.

Add the total credits that you may claim and enter the total in Step 3.

Step 4. Optional

Step 4(a). If you want tax withheld for other income this year that won't have withholding and the income is taxable in the United States, enter the amount of other income here. Do not include any income from any jobs or self-employment. See Pub. 519 for more information.

Step 4(b). Nonresident alien itemized deductions and adjustments to income may be limited. See Pub. 519 for more information. If you expect to claim itemized deductions and/or adjustments to income (such as the student loan interest deduction), add your itemized deductions and adjustments to income and enter the amount in Step 4(b).

Step 4(c). Write "nonresident alien" or "NRA" in the space below Step 4(c). If you would like to have an additional amount withheld, enter the amount in Step 4(c).

Exempt from withholding. Do not claim that you are exempt from withholding in the space below Step 4(c) of Form W-4 (even if you meet both of the conditions to claim exemption from withholding listed in the instructions to the Form W-4).