MT. SAN ANTONIO COLLEGE
Returning Adjunct Hiring Checklist and Acknowledgement Form

Name: _____ Banner ID: A_____

Optional paperwork is an opportunity for returning Adjunct to update employment information. Please confirm with Human Resources if TB Assessment, Live Scan, I-9 with supporting documentation and Minimum Qualifications are on file. Acknowledgement forms may have updated content so acknowledgement is required.

Employee Submitted	Required Paperwork
☐	Adjunct Rehire Form
☐	Live Scan Confirmation *(employee obtains live scan form from HR)*
☐	Tuberculosis Risk Assessment
Optional Paperwork:	
☐	Direct Deposit Authorization Form (*attached voided check)*
☐	Withholding Forms – Federal & State
☐	Employment Eligibility Verification–I-9 Form (*Instructions & list of acceptable documents on reverse side of I-9)*
☐	Social Security card (*for IRS purposes*)
☐	Oath of Allegiance
☐	Warrant Designation
☐	Hepatitis B Vaccination Program Form
☐	Worker's Compensation Pre-Designation Personal Physician Form
☐	CTA Membership Enrollment Form (*forward directly to Faculty Association Office*)
Adjunct Retirement Plans:	
☐	CalSTRS Permissive Election Form **(REQUIRED FORM)**
☐	SSA-1945 **(REQUIRED IF EMPLOYEE ELECTS STRS MEMBERSHIP)**
Informational Paperwork:	
☐	New Health Insurance Marketplace Coverage (ACA)

<u>Employee Acknowledgement</u>: Copies of all forms are available on the HR website at:

- Asbestos Notification and Acknowledgement
- FMLA Information and Acknowledgement
- Non-Discrimination Statement and Acknowledgement
- District Policy on Drug Free Environment and Acknowledgement
- Reasonable Accommodation Information and Acknowledgement
- Sexual Harassment Brochure and Acknowledgement
- Use of Technology and Information Resources and Employee Acceptable Use Agreement (AP 3720) Acknowledgement
- Emergency Response Quick Reference Guide
- Disaster Service Workers Brochure
- Worker's Compensation Information
- FMLA, PDL, and CFRA Information
- Notice of Social Security Alternative Plan – National Benefit Services (NBS) ***If CalSTRS membership is declined***

By signing this document, I hereby acknowledge that I have read, understand and agree to all requirements, policies and memos regarding my Adjunct position. Signature of this document also recognizes that all paperwork has been completed truthfully and to the best of my ability.

Employee Signature: _____ Date: _____

Employer Signature (Witness): _____ Date: _____

Mt. San Antonio College
Human Resources
ADJUNCT REHIRE FORM

Legal Name: _____ **Banner ID**: A_____
(Name on Social Security Card)

Gender: ☐ **Male** ☐ **Female** ☐ **Not Available**

Marital Status: ☐ **Unmarried** ☐ **Married** ☐ **Head of Household**
☐ **Divorced** ☐ **Separated** ☐ **Domestic Partner** ☐ **Widow(er)**

Current Address: _____
(Number and Street) (City , State, Zip Code)

Cell Phone No.:_____ **Alternate Phone No.:** (if applicable):_____

Campus-Wide Emergency Notifications Opt-in:

Phone:_____**Text:**_____

Emergency Contact Name: _____

Emergency Contact Phone No.: _____**Relationship:**_____

Are you currently a member of the California State Teachers Retirement System (CalSTRS)?
☐ Member ☐ Non-Member ☐ Retiree

Note: If you are currently a member with CalSTRS with any school district, member contributions must continue. Non-members may elect membership at any time. If you are interested in becoming a member, please complete CalSTRS Permissive Membership form (ES 0350).

DIVISION ACKNOWLEDGMENT

DISCIPLINE: _____ START DATE: _____

☐ The employee is rehired to teach the **same discipline** as before. MQ paperwork is on file.

☐ The employee is rehired to teach a **different discipline**. Attached is the Eligibility for Employment (MQ) form with documentation verifying MQs are met.

_____ _____
Division Dean Date

HUMAN RESOURCES USE ONLY			
☐ I-9	T.B Date:	ADJ Orientation:	Live Scan Clearance:
☐ Current Member CalSTRS Member ☐ NEW CalSTRS Member ☐ SSA-1945 ☐ National Benefit Services		Column/Step:	Banner Position No:

California School Employee Tuberculosis (TB) Risk Assessment Questionnaire

(for pre-K, K-12 schools and community college employees, volunteers and contractors)

- Use of this questionnaire is required by California Education Code sections 49406 and 87408.6, and Health and Safety Code sections 1597.055 and 121525-121555.^
- The purpose of this tool is to identify adults with infectious tuberculosis (TB) to prevent them from spreading disease.
- Do not repeat testing unless there are new risk factors since the last negative test.
- Do not treat for latent TB infection (LTBI) until active TB disease has been excluded:
  For individuals with signs or symptoms of TB disease or abnormal chest x-ray consistent with TB disease, evaluate for active TB disease with a chest x-ray, symptom screen, and if indicated, sputum AFB smears, cultures and nucleic acid amplification testing.
  A negative tuberculin skin test (TST) or interferon gamma release assay (IGRA) does not rule out active TB disease.

Name of Person Assessed for TB Risk Factors: _____

Assessment Date: _____ Date of Birth: _____

History of Tuberculosis Disease or Infection (Check appropriate box below)

☐ Yes
- If there is a documented history of positive TB test or TB disease, then a symptom review and chest x-ray (if none performed in the previous 6 months) should be performed at initial hire by a physician, physician assistant, or nurse practitioner. If the x-ray does not have evidence of TB, the person is no longer required to submit to a TB risk assessment or repeat chest x-rays.

☐ No (Assess for Risk Factors for Tuberculosis using box below)

TB testing is recommended if any of the 3 boxes below are checked

☐ One or more sign(s) or symptom(s) of TB disease
- TB symptoms include prolonged cough, coughing up blood, fever, night sweats, weight loss, or excessive fatigue.

☐ Birth, travel, or residence in a country with an elevated TB rate for at least 1 month
- Includes countries other than the United States, Canada, Australia, New Zealand, or Western and North European countries.
- Interferon gamma release assay (IGRA) is preferred over tuberculin skin test (TST) for non-US-born persons.

☐ Close contact to someone with infectious TB disease during lifetime

Treat for LTBI if TB test result is positive and active TB disease is ruled out

^The law requires that a health care provider administer this questionnaire. A health care provider, as defined for this purpose, is any organization, facility, institution or person licensed, certified or otherwise authorized or permitted by state law to deliver or furnish health services. A Certificate of Completion should be completed after screening is completed (page 3).

California School Employee Tuberculosis (TB) Risk Assessment User Guide

(for pre-K, K-12 schools and community college employees, volunteers and contractors)

Background

California law requires that school staff working with children and community college students be free of infectious tuberculosis (TB). These updated laws reflect current federal Centers for Disease Control and Prevention (CDC) recommendations for targeted TB testing. Enacted laws, AB 1667, effective on January 1, 2015, SB 792 on September 1, 2016, and SB 1038 on January 1, 2017, require a TB risk assessment be administered and if risk factors are identified, a TB test and examination be performed by a health care provider to determine that the person is free of infectious tuberculosis. The use of the California School Employee TB Risk Assessment and the Certificate of Completion, developed by the California Department of Public Health (CDPH) and California TB Controllers Association (CTCA) are also required.

AB 1667 impacted the following groups on 1/1/2015:

1. Persons employed by a K-12 school district, or employed under contract, in a certificated or classified position (California Education Code, Section 49406)

2. Persons employed, or employed under contract, by a private or parochial elementary or secondary school, or any nursery school (California Health and Safety Code, Sections 121525 and 121555).

3. Persons providing for the transportation of pupils under authorized contract in public, charter, private or parochial elementary or secondary schools (California Education Code, Section 49406 and California Health and Safety Code, Section 121525).

4. Persons volunteering with frequent or prolonged contact with pupils (California Education Code, Section 49406 and California Health and Safety Code, Section 121545).

SB 792 impacted the following group on 9/1/2016:

Persons employed as a teacher in a child care center (California Health and Safety Code Section 1597.055).

SB 1038 impacted the following group on 1/1/2017:

Persons employed by a community college district in an academic or classified position (California Education Code, Section 87408.6).

Testing for latent TB infection (LTBI)

Because an interferon gamma release assay (IGRA) blood test has increased specificity for TB infection in persons vaccinated with BCG, IGRA is preferred over the tuberculin skin test (TST) in these persons. Most persons born outside the United States have been vaccinated with BCG.

Previous or inactive tuberculosis

Persons with a previous chest radiograph showing findings consistent with previous or inactive TB should be tested for LTBI. In addition to LTBI testing, evaluate for active TB disease.

Negative test for LTBI does not rule out TB disease

It is important to remember that a negative TST or IGRA result does not rule out active TB disease. In fact, a negative TST or IGRA in a person with active TB can be a sign of extensive disease and poor outcome.

Symptoms of TB should trigger evaluation for active TB disease

Persons with any of the following symptoms that are otherwise unexplained should be medically evaluated: cough for more than 2-3 weeks, fevers, night sweats, weight loss, hemoptysis.

Most patients with LTBI should be treated

Because testing of persons at low risk of LTBI should not be done, persons that test positive for LTBI should generally be treated once active TB disease has been ruled out. However, clinicians should not be compelled to treat low risk persons with a positive test for LTBI.

Emphasis on short course for treatment of LTBI

Shorter regimens for treating LTBI have been shown to be more likely to be completed and the 3 month 12-dose regimen has been shown to be as effective as 9 months of isoniazid. Use of these shorter regimens is preferred in most patients. Drug-drug interactions and contact to drug resistant TB are typical reasons these regimens cannot be used.

Repeat risk assessment and testing

If there is a documented history of positive TB test or TB disease, then a symptom review and chest x-ray should be performed at initial hire. Once a person has a documented positive test for TB infection that has been followed by a chest x-ray (CXR) that was determined to be free of infectious TB, the TB risk assessment (and repeat x-rays) is no longer required.

Repeat risk assessments should occur every four years (unless otherwise required) to identify any additional risk factors, and TB testing based on the results of the TB risk assessment. Re-testing should only be done in persons who previously tested negative, and have new risk factors since the last assessment.

Please consult with your local public health department on any other recommendations and mandates that should also be considered.

Certificate of Completion
Tuberculosis Risk Assessment and/or Examination

*To satisfy **job-related requirements** in the California Education Code, Sections 49406 and 87408.6 and the California Health and Safety Code, Sections 1597.055, 121525, 121545 and 121555.*

First and Last Name of the person assessed and/or examined:

_____

Date of assessment and/or examination: _____mo./_____day/_____yr.

Date of Birth: _____mo./_____day/_____yr.

The above named patient has submitted to a tuberculosis risk assessment. The patient does not have risk factors, or if tuberculosis risk factors were identified, the patient has been examined and determined to be free of infectious tuberculosis.

X_____

Signature of Health Care Provider completing the risk assessment and/or examination

Please print, place label or stamp with Health Care Provider Name and Address (include Number, Street, City, State, and Zip Code):

California School Employee Tuberculosis Risk Assessment Frequently Asked Questions

California law requires that school staff working with children and community college students be free of infectious tuberculosis (TB). These updated laws reflect current recommendations for targeted TB testing from the federal Centers for Disease Control and Prevention (CDC), the California Department of Public Health (CDPH), the California Conference of Local Health Officers and the California Tuberculosis Controllers Association (CTCA).

What specifically did AB 1667 change on January 1, 2015?

1. Replaces the mandated TB examination on initial employment with a TB risk assessment, and TB testing based on the results of the TB risk assessment, for the following groups:
    a. Persons initially employed by a school district, or employed under contract, in a certificated or classified position (California Education Code, Section 49406)
    b. Persons initially employed, or employed under contract, by a private or parochial elementary or secondary school or any nursery school (California Health and Safety Code, Sections 121525 and 121555)
    c. Persons providing for the transportation of pupils under authorized contract (California Health and Safety Code, Section 121525)

2. Replaces the mandated TB examination at least once each four years of school employees who have no identified TB risk factors or who test negative for TB infection with a TB risk assessment, and TB testing based on the TB risk assessment responses. (California Education Code, Section 49406 and California Health and Safety Code, Section 121525)

3. Replaces mandated TB examination (within the last four years) of volunteers with "frequent or prolonged contact with pupils" in private or parochial elementary or secondary schools, or nursery schools (California Health and Safety Code, Section 121545) with a TB risk assessment administered on initial volunteer assignment, and TB testing based on the results of the TB risk assessment.

4. For school district volunteers with "frequent or prolonged contact with pupils," mandates a TB risk assessment administered on initial volunteer assignment and TB testing based on the results of the TB risk assessment. (California Education Code, Section 49406)

What specifically did SB 792 change on September 1, 2016?

California Health and Safety Code, Section 1597.055 requires that persons hired as a teacher in a child care center must provide evidence of a current certificate that indicates freedom from infectious TB as set forth in California Health Safety Code, Section 121525.

What specifically does SB 1038 change on January 1, 2017?

California Education Code, Section 87408.6 requires persons employed by a community college in an academic or classified position to submit to a TB risk assessment developed by CDPH and CTCA and, if risk factors are present, an examination to determine that he or she is free of infectious TB; initially upon hire and every four years thereafter.

California School Employee Tuberculosis Risk Assessment Frequently Asked Questions

Who developed the school staff and volunteer TB risk assessment?

The California Department of Public Health (CDPH) and the California Tuberculosis Controllers Association (CTCA) jointly developed the TB risk assessment. The risk assessment was adapted from a form developed by Minnesota Department of Health TB Prevention and Control Program and the Centers for Disease Control and Prevention.

Who may administer the TB risk assessment?

Per California Education and Health and Safety Codes, the TB risk assessment is to be administered by a health care provider. The risk assessment should be administered face-to-face. The practice of allowing employees or volunteers to self-assess is discouraged.

What is a "health care provider"?

A "health care provider" means any organization, facility, institution or person licensed, certified or otherwise authorized or permitted by state law to deliver or furnish health services.

If someone is a new employee and has a TB test that was negative, would he/she need to also complete a TB risk assessment?

Check with your employer about what is needed at the time of hire.

If someone transfers from one K-12 school or school district to another school or school district, would he/she need to also complete a TB risk assessment?

Not if that person can produce a certificate that shows he or she was found to be free of infectious tuberculosis within 60 days of initial hire, or the school previously employing the person verifies that the person has a certificate on file showing that the person is free from infectious tuberculosis.

If someone does not want to submit to a TB risk assessment, can he/she get a TB test instead?

Yes, a TB test, and an examination if necessary, may be completed instead of submitting to a TB risk assessment.

If someone has a positive TB test, can he/she start working before the chest x-ray is completed?

No, the x-ray must be completed and the person determined to be free of infectious TB prior to starting work.

If someone has a positive TB test, does he/she need to submit to a chest x-ray every four (4) years?

No, once a person has a documented positive TB test followed by an x-ray, repeat x-rays are no longer required every four years. If an employee or volunteer becomes symptomatic for TB, then he/she should promptly seek care from his/her health care provider.

California School Employee Tuberculosis Risk Assessment Frequently Asked Questions

What screening is required for someone who has a history of a positive TB test or TB disease at hire?

If there is a documented history of positive TB test or TB disease, then a symptom review and chest x-ray (if none performed in previous 6 months) should be performed at initial hire by a physician, physician assistant, or nurse practitioner. Once a person has a documented positive test for TB infection that has been followed by an x-ray that was determined to be free of infectious TB, the TB risk assessment (and repeat x-rays) is no longer required. If an employee or volunteer becomes symptomatic for TB, then he/she should seek care from his/her health care provider.

For volunteers, what constitutes "frequent or prolonged contact with pupils"?

Examples of what may be considered "frequent or prolonged contact with pupils" include, but are not limited to, regularly-scheduled classroom volunteering and field trips where cumulative face-to-face time with students exceeds 8 hours.

Who may sign the Certificate of Completion?

- If the patient has no TB risk factors then the health care provider completing the TB risk assessment may sign the Certificate of Completion.
- If a TB test is performed and the result is negative, then the licensed health care provider interpreting the TB test may sign the Certificate.
- If a TB test is positive and an examination is performed, only a physician, physician assistant, or nurse practitioner may sign the Certificate.

What does "determined to be free of infectious tuberculosis" mean on the Certificate of Completion?

"Determined to be free of infectious TB" means that a physician, physician assistant, or nurse practitioner has completed the TB examination and provided any necessary treatment so that the person is not contagious and cannot pass the TB bacteria to others. The TB examination for active TB disease includes a chest x-ray, symptom assessment, and if indicated, sputum collection for acid-fast bacilli (AFB) smears cultures and nucleic acid amplification testing.

What if I have TB screening or treatment questions?

Consult the federal Centers for Disease Control and Prevention's *Latent Tuberculosis Infection: A Guide for Primary Health Care Providers* (2013) (http://www.cdc.gov/tb/publications/LTBI/default.htm). If you have specific TB screening or treatment questions, please contact your local TB control program (http://www.ctca.org/locations.html).

Who may I contact to get further information or to download the TB risk assessment?

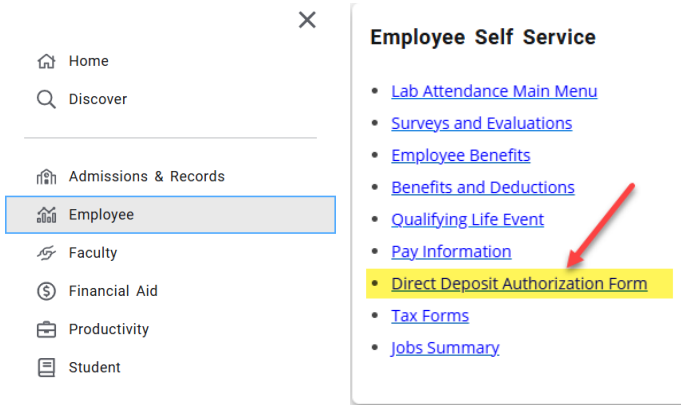
- California Tuberculosis Controllers' Association
  https://www.ctca.org/providers/
- California Department of Public Health, Tuberculosis Control Branch: (510) 620-3000
  https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/TBCB.aspx
- California School Nurses Organization: (916) 448-5752 or email csno@csno.org
  http://www.csno.org/

6/25/18

Direct Deposit Authorization through Portal
inside.mtsac.edu

Step 1: After logging into inside.mtsac.edu, click on three lines "hamburger" for **Main Menu.**

Step 2: Click on "**Employee**" page, and under "**Employee Self Service**" card, click on "**Direct Deposit Authorization Form**" link.

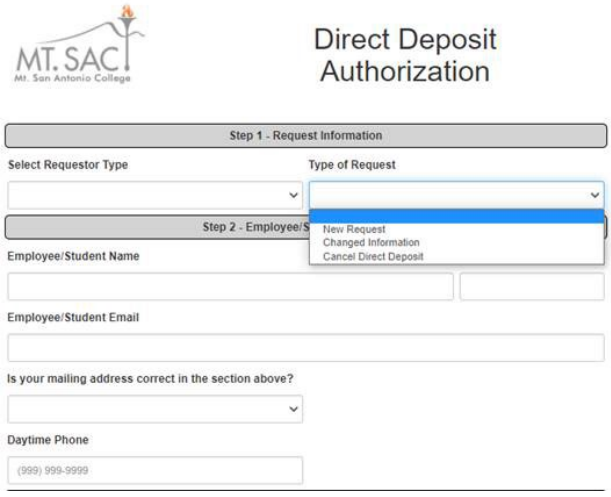


Step 3: Fill out information.

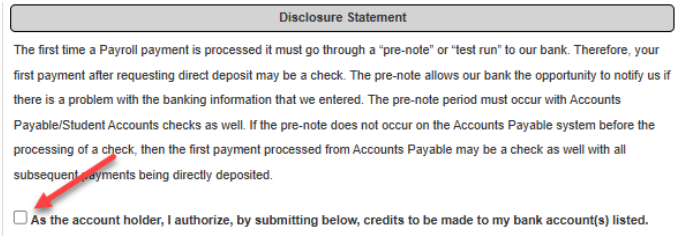
a) New Request – If setting up for the first time.

b) Changed Information – If changing information such as adding or replacing another account.

c) Cancel Direct Deposit – If completely cancelling and not providing a replacement account.



Step 4: Click box to authorize college to send funds to your account.



Step 5: Enter bank information.

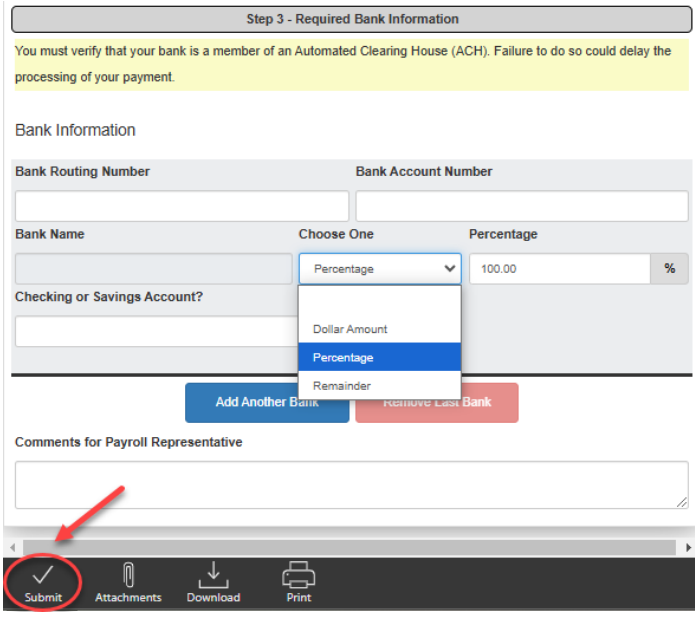
a) Bank Routing Number: Type in number. Pause until you can select name from drop down.

b) Bank Account Number: Type in.

c) Bank Name: DO NOT type in. Form will not allow. Must select from routing number drop down.

d) Choose One:

1) If only one account listed: Choose Percentage and enter 100%.
2) If more than one account:
   - Account 1: Choose Dollar Amount or Percentage and specify how much.
   - Account 2: Click "Add Another Bank" and choose Remainder.
     *Can have multiple (more than 2) accounts.



Step 6: Click Submit.

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)
Mt. San Antonio College 1100 N. Grand Avenue, Walnut, CA 91789		

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

Employment Development Department
State of California

EMPLOYEE'S WITHHOLDING ALLOWANCE CERTIFICATE

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

Enter Personal Information	
First, Middle, Last Name	Social Security Number
Address City, State, and ZIP Code	Filing Status ☑ SINGLE or MARRIED (with two or more incomes) ☐ MARRIED (one income) ☐ HEAD OF HOUSEHOLD

1. Total Number of Allowances you're claiming (Use Worksheet A for regular withholding allowances. Use other worksheets on the following pages as applicable, Worksheet A+B). _____

2. Additional amount, if any, you want withheld each pay period (if employer agrees), **(Worksheet B and C)** _____
   OR

Exemption from Withholding

3. I claim exemption from withholding for 2020, and I certify I meet both of the conditions for exemption. ☐
   OR
   Write "Exempt" here

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. (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
Mt. San Antonio College 1100 N. Grand Ave Walnut, CA 91789	

PURPOSE: This certificate, DE 4, is for **California Personal Income Tax (PIT) withholding** purposes only. The DE 4 is used to compute the amount of taxes to be withheld from your wages, by your employer, to accurately reflect your state tax withholding obligation.

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

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

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

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

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

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

Member Service Civil Relief Act: Under this act, as amended by the Military Spouses Residency Relief Act, you may be exempt from California income tax 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) (PDF, 2.4 MB)** (edd.ca.gov/pdf_pub_ctr/de44.pdf) provides the income tax withholding tables. This publication may be found by visiting **Forms and Publications** (edd.ca.gov/Payroll_Taxes/Forms_and_Publications). 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 Franchise Tax Board (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)**, 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** and section 19176 of the **Revenue and Taxation Code**.

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 1 of the DE 4	(F) _____

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 $9,074 if married filing joint with two or more allowances, unmarried head of household, or qualifying widow(er) with dependent(s) or $4,537 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.	_____
4.	Enter an estimate of your adjustments to income (alimony payments, IRA deposits)	+ 4.	_____
5.	Add line 4 to line 3, enter sum	= 5.	_____
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.	_____
8.	Divide the amount on line 7 by $1,000, round any fraction to the nearest whole number	8.	_____
	Add this number to Line F of Worksheet A and enter it on line 1 of the DE 4. Complete Worksheet C, if needed, otherwise **stop here**.		
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.	_____
11.	Subtract line 10 from line 9, enter difference	11.	_____
	Complete Worksheet C		

*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 2020.	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.
8.	Figure your tax liability for the amount on line 7 by using the 2020 tax rate schedules below.	8.
9.	Enter personal exemptions (line F of Worksheet A x $134.20).	9.
10.	Subtract line 9 from line 8. Enter difference.	10.
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.
13.	Calculate the tax withheld and estimated to be withheld during 2020. 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 2020. 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 2020.	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.
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 2020 ONLY

SINGLE PERSONS, DUAL INCOME MARRIED WITH MULTIPLE EMPLOYERS

IF THE TAXABLE INCOME IS		COMPUTED TAX IS		
OVER	BUT NOT OVER	OF AMOUNT OVER...		PLUS
$0	$8,809	1.100%	$0	$0.00
$8,809	$20,883	2.200%	$8,809	$96.90
$20,883	$32,960	4.400%	$20,883	$362.53
$32,960	$45,753	6.600%	$32,960	$893.92
$45,753	$57,824	8.800%	$45,753	$1,738.26
$57,824	$295,373	10.230%	$57,824	$2,800.51
$295,373	$354,445	11.330%	$295,373	$27,101.77
$354,445	$590,742	12.430%	$354,445	$33,794.63
$590,742	$1,000,000	13.530%	$590,742	$63,166.35
$1,000,000	and over	14.630%	$1,000,000	$118,538.96

UNMARRIED HEAD OF HOUSEHOLD

IF THE TAXABLE INCOME IS		COMPUTED TAX IS		
OVER	BUT NOT OVER	OF AMOUNT OVER...		PLUS
$0	$17,629	1.100%	$0	$0.00
$17,629	$41,768	2.200%	$17,629	$193.92
$41,768	$53,843	4.400%	$41,768	$724.98
$53,843	$66,636	6.600%	$53,843	$1,256.28
$66,636	$78,710	8.800%	$66,636	$2,100.62
$78,710	$401,705	10.230%	$78,710	$3,163.13
$401,705	$482,047	11.330%	$401,705	$36,205.52
$482,047	$803,410	12.430%	$482,047	$45,308.27
$803,410	$1,000,000	13.530%	$803,410	$85,253.69
$1,000,000	and over	14.630%	$1,000,000	$111,852.32

MARRIED PERSONS

IF THE TAXABLE INCOME IS		COMPUTED TAX IS		
OVER	BUT NOT OVER	OF AMOUNT OVER...		PLUS
$0	$17,618	1.100%	$0	$0.00
$17,618	$41,766	2.200%	$17,618	$193.80
$41,766	$65,920	4.400%	$41,766	$725.06
$65,920	$91,506	6.600%	$65,920	$1,787.84
$91,506	$115,648	8.800%	$91,506	$3,476.52
$115,648	$590,746	10.230%	$115,648	$5,601.02
$590,746	$708,890	11.330%	$590,746	$54,203.55
$708,890	$1,000,000	12.430%	$708,890	$67,589.27
$1,000,000	$1,181,484	13.530%	$1,000,000	$103,774.24
$1,181,484	and over	14.630%	$1,181,484	$128,329.03

If you need information on your last California Resident Income Tax Return, FTB Form 540, visit **Franchise Tax Board (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 05/31/2027

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
Mt. San Antonio College	**1100 N. Grand Avenue, Walnut, CA 91789**

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

LISTS OF ACCEPTABLE DOCUMENTS

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

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

Acceptable Receipts

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

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

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

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

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

USCIS
Form I-9
Supplement A
OMB No. 1615-0047
Expires 05/31/2027

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

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

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

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

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

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

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

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

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

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

Supplement B,
Reverification and Rehire (formerly Section 3)

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

USCIS Form I-9 Supplement B
OMB No. 1615-0047
Expires 05/31/2027

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.

MT. SAC
Mt. San Antonio College

HUMAN RESOURCES

OATH OF ALLEGIANCE

(Required by Government Code)

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

_____
Signature of Employee

THE OATHS ABOVE SUBSCRIBED AND AFFIRMED TO BEFORE ME ON THIS Select Day *DAY OF* Select Month *, 20* Select Y

WITNESS NAME: _____

WITNESS TITLE: _____

MT. SAC
Mt. San Antonio College

HUMAN RESOURCES

LAST PAY WARRANT (Check)

In the event of your death, salary or other monies may be owed to you as an employee of our district. The form below permits immediate release of any warrants (checks) to a person you designate. This can often greatly assist in time of family stress or financial need. Please complete the form and return it to the district Office of Human Resources.

WARRANT RECIPIENT DESIGNATION

(Please Print or Type)

As provided in Section 53245 of the California Government Code in the event of my death, I hereby designate_____(designee) to receive any and all warrants payable to me.

Name of DESIGNEE:_____Relationship:_____

Address:_____City:_____State:_____Zip:_____

Telephone:_____

This designation form cancels and replaces any designation previously signed for this purpose and shall remain in effect until cancelled in my writing.

It is understood and agreed that the school district/agency is not obligated to deliver said warrants to the designee unless the designated person claims such warrants from the school district and provides sufficient proof of identity. A person so designated may negotiate the warrant(s) as if the payee.

School District/Agency:_____Mt. San Antonio College_____

EMPLOYEE:_____Date:_____

SIGNATURE:_____

lm 7/04; lr 5/13
c:HRS/Forms/New Hire Forms/Warrant Designation

HOW IS THE VACCINE ADMINISTERED?

The vaccination process consists of three separate injections into the upper arm. The injections are administered over a six-month period according to the following schedule:

First dose:	On elected date (i.e., September 1);
Second dose:	One month later (i.e., October 1);
Third dose:	Six months after the first dose (i.e., March 1)

The Mt. San Antonio College District requires that employees opting for the vaccination sign consent form and that those employees who decline to accept the Hepatitis B vaccination sign a declaration statement. Please indicate your intentions by checking the appropriate response below:

☒ No My assignment does not require occupational exposure to blood or body fluids.

☐ No I have been vaccinated and/or have had Hepatitis B.

☐ No I have been informed of the above matter. I do not wish to participate in the Hepatitis B vaccination program.

I understand that due to my exposure to blood or other potentially infectious materials, I may be at risk of acquiring Hepatitis B virus (HBV) infection. I have been given the opportunity to be vaccinated with Hepatitis B vaccine. However, I decline the Hepatitis B vaccination at this time. I understand by declining this vaccine, I continue to be at risk of acquiring Hepatitis B, a serious disease. If in the future I continue to have exposure to blood or other potentially infectious materials and I want to be vaccinated with Hepatitis B vaccine, I understand that the immunization will remain available to me at no cost.

☐ Yes My job assignment includes contact with blood and body fluids. I wish to participate in the Hepatitis B Vaccination Program including the formal education. Please contact Health Services at (909) 274-4400 to make an appointment.

Signature:_____Date: _____

Print name: _____

Department: _____

Position: _____

Further questions regarding information contained in this memo may be directed to Health Services at extension 4400.

Mt. San Antonio College

Worker's Compensation Pre-Designation of Personal Physician

If you have health insurance and you are injured on the job, you have the right to be treated immediately by your personal physician (M.D., D.O) or medical group if you notify your employer, in writing, prior to the injury. Per Labor Code Section 4600 to qualify as your predesignated, personal physician, the physician must agree, in writing, to treat you for a work-related injury, must have previously directed your medical care, and must retain your medical history and records. Your predesignated physician must be a family practitioner, general practitioner, board certified or board eligible internist, obstetrician-gynecologist or pediatrician. Your "personal physician" may be a medical group if it is a single corporation or partnership composed of licensed doctors or medicine or osteopathy that operates an integrated multi-specialty medical group providing comprehensive medical services predominantly for non-occupational illnesses and injuries.

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

Employee Name: _____

Employee Address: _____

City: _____ State: _____ Zip Code: _____

☒ I acknowledge receipt of this form and elect not to predesignate my personal physician at this time. I understand that I will receive medical treatment from my employers' medical provider. I understand that, at any time in the future, I can change my mind and provide written notification of my personal physician. I understand that the written notification must be on file prior to an industrial injury.

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

Physician Name / Medical Group: _____ Phone: (_____) _____-_____

Physician / Medical Group Address: _____

City: _____ State: _____ Zip Code: _____

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

Insurance Company, Plan, or Fund providing Health coverage for non-occupational injuries or illnesses.

Employee Signature: _____ Date: _____ / _____ / _____

A Personal Physician must be willing to be predesignated and treat you for a workers' compensation injury. Your personal physician should complete the remainder of this form and return it to Mt. San Antonio College.

PERSONAL PHYSICIAN ACKNOWLEDGEMENT

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

Physician's Name / Medical Group: _____

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

_____ _____ / _____ / _____

Physician or Designated Employee of the Physician or Medical Group Date

PLEASE RETURN TO MT. SAN ANTONIO COLLEGE 1100 N. GRAND AVENUE, WALNUT, CA 91789 or FAX TO 909.274.2994

CALIFORNIA TEACHERS ASSOCIATION | NATIONAL EDUCATION ASSOCIATION | CCA COMMUNITY COLLEGE ASSOCIATION

YEAR 20___ - 20___

MEMBERSHIP ENROLLMENT FORM CCA

Your Advocate. Your Partner. Your CTA.

Thank you for choosing a career in education. While it's personally rewarding, it's also professionally demanding. That's why NEA, CTA and your local association will provide you the support you need to be great at what you do. Being a member connects you with other educators. Together, we've been the most powerful voice for students and public education in California since 1863. And together, we still are. ***We do this by:***

- ☑ **Negotiating fair salaries, health care and other benefits**
- ☑ **Leading student-centered educational improvements**
- ☑ **Supporting your professional practice with conferences, workshops, grants and scholarships**
- ☑ **Improving learning and working conditions**
- ☑ **Enhancing and defending your professional rights**
- ☑ **Providing cost-saving benefits designed just for educators**

PERSONAL INFORMATION

CTA Membership ID or Previous Employer/School District

_____

First Name _____ MI _____

Last Name _____

Last 4 of SSN _____

Home Address _____

_____ Apt _____

City _____

State _____ Zip _____

Land Line _____

Cell Phone* _____

** See next page for information*

Home Email _____

CTA/ABC & INDEPENDENT EXPENDITURES ALLOCATION *(Optional)*

Designated portions of CTA dues are allocated to the Association for Better Citizenship (CTA/ABC) and to Independent Expenditures (IE) through which CTA provides financial support for education-related issues (CTA/ABC) and CTA-endorsed bipartisan candidates for local and state offices (CTA/ABC and IE).

☐ Please indicate if you choose not to allocate a portion of your dues to the CTA/ABC and the IE account and want all your dues to remain in the general fund.

MEMBERSHIP INFORMATION

Local Association _____

Current Employer/ School District _____

Hire Date _____ Primary Employer? ☐ Yes ☐ No

If no, list employer _____

Job Title _____

Building/Work Site _____

FACULTY ASSIGNMENT INFORMATION

☐ **Category 1**
Full-Time

☐ **Category 4**
Part-Time or Hourly

FOR OFFICE USE ONLY
ANNUAL DUES AMOUNTS

NEA: _____

CTA/CCA: _____

LEA: _____

NEA FUND: _____

TOTALS _____

NEA FUND DEDUCTION AUTHORIZATION *(Optional)*

I agree to contribute $_____ *annually* to the NEA Fund. The NEA Fund for Children and Public Education (NEA Fund) collects voluntary contributions from Association members and uses these contributions for political purposes, including, but not limited to, making contributions to and expenditures on behalf of friends of public education who are candidates for federal office. ** See reverse for more information.

CTA VOLUNTARY CONTRIBUTION

All CTA dues include a $20 voluntary contribution per year to help fund CTA advocacy efforts and fund the CTA Foundation for Teaching and Learning, which provides scholarships to members and supports teacher-led efforts to improve public schools. To opt out of the voluntary contribution, complete a Voluntary Contribution Change Form. Forms are available at www.cta.org/contribution, from your local membership contact or via email at membership@cta.org.

MEMBERSHIP, DUES PAYMENT AND DUES DEDUCTION AUTHORIZATION

YES, I want to join with my fellow employees and be a committed member of the Local Association, the California Teachers Association (CTA), and the National Education Association (NEA). I hereby request and voluntarily accept membership in these associations and agree to abide by the Constitution and Bylaws of all three associations, as they may be amended from time to time. I support the Local Association in its role as my exclusive representative in collective bargaining over wages, hours, and other terms and conditions of employment.

I hereby (1) agree to pay annual dues uniformly required for membership in the Local, CTA, and NEA; and (2) request and authorize my Employer to deduct from my pay in each pay period, and transmit to CTA or its designated agent, a pro rata portion of the annual dues required for membership in the Local, CTA, and NEA, unless I pay dues by check. I fully understand that the dues required for membership in the three associations are subject to periodic change by the associations' governing bodies and authorize dues payment on a continuing basis, and regardless of my membership status, unless my obligation to do so ends under one of the circumstances below. This agreement to pay dues continues from year to year, regardless of my membership status, unless: I revoke it by sending written notice via U.S. mail to CTA Member Services, P.O. Box 4178, Burlingame, CA 94011, not less than thirty (30) days and not more than sixty (60) days before the annual anniversary date of this agreement; my employment with the Employer ends; or as otherwise required by law.

I understand that this agreement is voluntary and is not a condition of employment and that I have the legal right not to sign this agreement.

Member Signature _____ **Date** _____

CTA MEMBERSHIP DEPARTMENT COPY

Continue on the back side →

DEMOGRAPHIC INFORMATION *(Optional)*

Ethnicity

- ☐ African American
- ☐ American Indian/ Alaska Native
- ☐ Asian
- ☐ Caucasian
- ☐ Hispanic
- ☐ Multi-Ethnic
- ☐ Native Hawaiian/ Pacific Islander
- ☐ Other
- ☐ Unknown

Gender

- ☐ Female
- ☐ Male
- ☐ Non-Binary

Birthdate _____ (mm/dd/yyyy)

Social Media Used:

- ☐ Instagram
- ☐ Pinterest
- ☐ Facebook
- ☐ Twitter

HOW CAN WE BEST SUPPORT YOU? *(Optional)*

1. **What year did you begin working in higher education?**

   ☐☐☐☐ (YYYY)

2. **I am:**

   - ☐ Already a member
   - ☐ Joining the Association today
   - ☐ Interested in receiving more information about membership

3. **Our Association provides resources and support to members to ensure student success. What areas of support would be most useful to help you and your students succeed?**

   - ☐ Social and racial justice
   - ☐ Effective pedagogy
   - ☐ Community engagement
   - ☐ Fully funded colleges and universities
   - ☐ Education policy - *policy that impacts your college/ university at the local, state or national level*
   - ☐ Political advocacy - *advocate for policies that ensure all students get the opportunities that they deserve*

4. **Our Association advocates for conditions that retain high-quality educators for every student. Which of these are you interested in learning about?**

   - ☐ Salary
   - ☐ Educator Rights & Responsibilities
   - ☐ Health Care Benefits
   - ☐ Pensions and Retirement Security
   - ☐ Student Debt and/or Finances
   - ☐ Stretching Your Paycheck
   - ☐ Working Conditions

MORE INFORMATION

*By providing my phone number, I understand that the NEA and its affiliates including CTA, the Local, NEA Member Benefits, and NEA360 may use automated calling technologies and/or text message me on my cellular phone on a periodic basis. NEA and its affiliates will never charge for text message alerts. Carrier message and data rates may apply to such alerts. Text STOP in response to an NEA, CTA or Local text message to stop receiving the association's messages.

**Only U.S. citizens or lawful permanent residents may contribute to the NEA Fund. Contributions to the NEA Fund are voluntary; making a contribution is neither a condition of employment nor membership in the Association, and members have the right to refuse to contribute without suffering any reprisal. Although the NEA Fund requests an annual contribution of $50, this is only a suggestion. A member may contribute more or less than the suggested amount, or may contribute nothing at all, without it affecting his or her membership status, rights or benefits in NEA or any of its affiliates. Contributions to the NEA Fund are not deductible as charitable contributions for federal income tax purposes. Federal law requires political committees to report the name, mailing address, occupation, and name of employer for each individual whose contributions aggregate in excess of $200 in a calendar year.

Permissive Membership
ES 0350 REV 03/20

[For CalSTRS' Official Use Only]

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

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

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

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

Provide either your CalSTRS Client ID or Social Security number.

CLIENT ID

SOCIAL SECURITY NUMBER

LAST NAME

FIRST NAME

MI

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

CITY

STATE

ZIP CODE

DATE OF BIRTH (MM/DD/YYYY)

EMAIL ADDRESS

TELEPHONE

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

Check One:

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

MEMBERSHIP DATE (MM/DD/YYYY)**

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

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

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

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

ES0350

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

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

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

EMPLOYEE SIGNATURE	DATE (MM/DD/YYYY)

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

POSITION TITLE	POSITION HIRE DATE

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

Required Signature

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

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

EMPLOYER OFFICIAL'S SIGNATURE	DATE (MM/DD/YYYY)
EMPLOYER NAME	COUNTY AND DISTRICT CODE
Mt. San Antonio College	**19 630**
EMPLOYER OFFICIAL'S NAME AND TITLE	

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

Employee Name _____ **Employee ID#** _____

Employer Name Mt. San Antonio College **Employer ID#** 19-630

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

Windfall Elimination Provision

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

Government Pension Offset Provision

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

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

For More Information

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

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

Signature of Employee _____ **Date** _____

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

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

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

Employers must:

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

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

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

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
expires 5-31-2020

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that does not meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution -as well as your employee contribution to employer- offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact Melissa Aguirre (909) 274-5419 or Norma Vizcarra (909) 274-5872

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit **HealthCare.gov** for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

[1] An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name	4. Employer Identification Number (EIN)
Mt. San Antonio Community College District	95-600-21-31
5. Employer address	**6. Employer phone number**
1100 N. Grand Ave.	(909) 274-7500

7. City	8. State	9. ZIP code
Walnut	CA	91789

10. Who can we contact about employee health coverage at this job?
Melissa Aguirre (909) 274-5419 or Norma Vizcarra (909) 274-5872

11. Phone number (if different from above)	12. Email address
N/A	maguirre@mtsac.edu; nvizcarra4@mtsac.edu

Here is some basic information about health coverage offered by this emplo yer:

- As your emplo yer, we offer a health plan to:
  - ☐ All employees. Eligible employees are:
  - ☐ Some emplo yees. Eligible employees are:

    Permanent full-time and permanent part-time employees working a 50% or greater position.
    Adjunct Faculty must have worked four consecutive semesters, Fall or Spring, and must maintain three(3) LHE's (Lecture Hours Equivalent) for credit adjunct faculties and six (6) hours of instruction per week for non-credit adjunct faculties to qualify for health coverage.
- With respect to dependents:
  - ☐ We do offer coverage. Eligible dependents are:

    Current spouse/domestic partner; natural, adopted, step or registered domestic partner's children up to age 26. Disabled children of any age if enrolled prior to age 26 and children up to age 26 for whom the subscriber has assumed a parent-child relationship and is considered the primary parent.
  - ☐ We do n t offer coverage.

☐ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, **HealthCare.gov** will guide you through the process. Here's the employer information you'll enter when you visit **HealthCare.gov** to find out if you can get a tax credit to lower your monthly premiums.

The information below corresponds to the Marketplace Employer Coverage To l. Completing this section is optional for employers, but will help ensure employees understand their coverage choices.

13. **Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?**

☐ **Yes** (Continue)
13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage? _____ (mm/dd/yyyy) (Continue)
☐ **No** (STOP and return this form to employee)

14. Does the employer offer a health plan that meets the minimum value standard*?
☐ Yes (Go to question 15) ☐ No (STOP and return form to employee)

15. For the lowest-cost plan that meets the minimum value standard* **offered only to the employee** (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/ she the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.
. How much would the employee have to pay in for this plan? $_____
. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and return form t employee.

16. What change will the employer make for the new plan year?_____
☐ Employer won't offer health coverage
☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)
a. How much would the employee have to pay in premiums for this plan? $_____
b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

• An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36 (c)(2)(C)(ii) of the Internal Revenue Code f 19 6)