LOS RIOS COMMUNITY COLLEGE DISTRICT - COMPLIANCE CHECKLIST

Temporary Classified / Student Help / Federal Work Study Employees

EMPLOYEE NAME: _____

LAST, **FIRST** **M.I.** **Employee ID OR Last Four Digits of SSN**

1. **NEW EMPLOYEE TRAINING CHECKLIST – *SUBMIT TO HUMAN RESOURCES***
   #7 listed on of the New Employee Training Checklist, is the specific "Job Safety Analyses". The Job Safety Analyses for your position available to download at the Los Rios website. It can be printed out by any Los Rios employee (i.e., your supervisor). Directions to print out a Job Safety Analysis form: 1) Go to https://losrios.edu website address. 2) Click on "Employees". 3) Click on "HR & Benefits". 4) Click on "Human Resources". 5) Click on "Job Descriptions and Safety Analyses", then choose the job title of the position and print out the appropriate Job Safety Analyses, if applicable your hiring supervisor can assist.

2. **NOTICE OF WORKER'S COMPENSATION PACKET – *SUBMIT TO HUMAN RESOURCES***
   Notice to New Employees - Worker's Compensation; CA Worker's Compensation - What Every Worker Should Know; Designated Medical Facilities for Worker's Compensation Treatment; Optional "Predesignation of Personal Physician" form; and the pamphlet: Facts about Workers Compensation.

3. **SSA-1945 FORM – *SUBMIT TO HUMAN RESOURCES***
   I understand this form is only applicable if I am in a position which is NOT covered by Social Security. This applies to all Student Help/Federal Work Study employees AND to Temporary Classified employees who contribute into Public Agency Retirement Services (PARS). (Exception: If I am hired as a Temporary Classified employee and I am already a member of CalPERS, then this form is ***NOT*** applicable.)

4. **NOTICE OF EXCLUSION FROM CALPERS MEMBERSHIP – *SUBMIT TO HUMAN RESOURCES***
   I have been given and completed the Notice of Exclusion from CalPERS Membership form. (Exception: If I am hired as a Temporary Classified employee and I am already a member with CalPERS, then this form is ***NOT*** applicable.)

5. **EMPLOYEE FERPA AGREEMENT - *SUBMIT TO HUMAN RESOURCES* -** I have been given and completed the Employee FERPA Agreement form.

6. **HEPATITIS B VACCINATION ACCEPTANCE OR DECLINATION FORM – *IF APPLICABLE, SUBMIT TO HUMAN RESOURCES***
   Hepatitis B Vaccination Acceptance or Declination form MUST be submitted to Human Resources and Bloodborne Pathogens training MUST be completed, if required per job classification/position. If further information is needed, please visit the web page at https://employees.losrios.edu/lrccd/employee/doc/gs/forms/gs-178.pdf

7. **TITLE IX: MANDATORY TRAINING, SEXUAL HARASSMENT & SEXUAL VIOLENCE, AND HOW TO REPORT IT ("NOT ANYMORE") - *GIVEN TO EMPLOYEE***
   I received the Mandatory Title IX Training information packet and understand that I have **30 days to complete** the online training through Employee Self-Service. This training is only required once, at the time of hire.

8. **KEENAN SAFECOLLEGES ONLINE TRAINING - *GIVEN TO EMPLOYEE***
   I received the Mandatory Sexual Harassment Prevention for Non-Managers (SB 1343) training directions packet, along with 6 additional highly recommended trainings to complete, and understand that I have **14 days from my start date** to complete this online training.

9. **POLICIES & REGULATIONS, CONFLICT OF INTEREST RULES AND COMPUTER USE REGULATIONS – *GIVEN TO EMPLOYEE***
   I understand that Los Rios Policies and Regulations are available on the Los Rios Website. To review go to: https://losrios.edu/about-us/board-of-trustees/policies-and-regulations then click on "Board Policies". Click on the "8000 - Business Policies" series and review the policy numbered "8631 - Conflict of Interest Rules". The Computer Use Regulations are located under "Administrative Regulations" area. Click on the "8000 - Business Regulations" series and review all regulations under the "8800 - Administrative Computer Use".

10. **EMPLOYEE RIGHTS AND RESPONSIBILITIES PACKET; LABOR COMMISSIONER'S OFFICE: RIGHTS OF VICTIMS – *GIVEN TO EMPLOYEE***
    Includes information on: Non Discrimination and Disability Accommodation; Sexual Harassment / Non Discrimination / Violence-Free Workplace / Drug and Alcohol Free Workplace; Workplace Bullying; Professional/Ethical Behavior; Clery Act; Administrative Computer Use and Regulations; Information Available Online; Bloodborne Pathogens and Local Counseling and Rehabilitation Programs. The Labor Commissioner's office Rights of Victims of domestic violence, sexual assault and stalking – rights to time off, reasonable accommodation, freedom from retaliation and discrimination.

11. **EMPLOYEE SELF SERVICE INFORMATION – *GIVEN TO EMPLOYEE***
    Form provides directions to access Employee Self Service internet pages including completing of my Federal and State tax withholding options. (i.e., access to update Emergency Contact, review Pay Warrants, sign up for Direct Deposit, etc.).

12. **BENFITS INFORMATION - *GIVEN TO EMPLOYEE (a and b)***
    a. **HEALTH INSURANCE MARKETPLACE NOTICE TO NEW HIRES -** Information on the Health Insurance Marketplace as part of the Affordable Care Act.
    b. **PAID SICK LEAVE –** Notification of sick leave per Labor Code section 245, Accrual of Paid Sick Leave, and Use of Paid Sick Leave.
    c. **VOLUNTARY BENEFIT PROGRAM (Medical Program)** - Go to: https://www.keenandirect.com or call (855) 653-3626 or call (916) 568-3070 for a flyer.

13. **PUBLIC AGENCY RETIREMENT SERVICES (PARS) INFORMATION -** (PARS information applies to MOST Temporary Classified employees and does not apply to Student employees). I understand that if I am a Temporary Classified employee AND I am being hired for a position which I will contribute into PARS, then the following PARS ARS 457 forms will apply to me: Plan Information Sheet, Frequently Asked Questions and Designation of Beneficiary Form. These and other PARS related forms are available at the Los Rios website: https://employees.losrios.edu/employee-groups/temporary-employees/public-agency-retirement-services-(pars)

14. **ADA & FEHA Information / EDD BOOKLET -** The District is in compliance with Americans with Disabilities Act (ADA)/ Fair Employment and Housing Act (FEHA) and provides reasonable accommodations to individuals with disabilities. Information and questions can be located at: https://losrios.edu/about-us/our-values/disability-accommodation. The EDD Booklet entitled "For Your Benefit - California's Programs for the Unemployed". Further information about either of these items is available in Human Resources and/or the Vice President offices on campus.

15. **403(b) or 457 TAX SHELTERED ANNUITY (TSA) PLAN FOR TEMPORARY CLASSIFIED EMPLOYEES ONLY -** I understand that I may be eligible to participate in a Los Rios sponsored 403(b) and/or 457 Tax Sheltered Annuity (TSA) plan. If interested, I will contact the Los Rios Benefits Department at (916) 568-3070.

I have received (when applicable), read and agree to comply with the material and information that I have been given as listed above which apply to the position for which I am being hired. If I have any questions regarding this material or information, I will contact a Human Resources representative. (For Student Help/Federal Work Study/Temporary Classified questions, call (916) 568-3107.

EMPLOYEE SIGNATURE **DATE**

Revised: 11-2022

HUMAN RESOURCES COPY

Los Rios Community College District
NEW EMPLOYEE TRAINING CHECK LIST

This form is to be completed during the processing as a new employee or new job assignment if the assignment falls in a new JOB SAFETY ANALYSIS area. This form will be kept in your personnel file. **Each area must be completed.**

Name: _____ Emplid or last four of SSN: _____

Print Name Clearly

Work Location: ☐ ARC / ☐ CRC / ☐ DO / ☐ ETHAN / ☐ FLC / ☐ FM / ☐ SCC

Dept/Division Area: _____

Area Dean/Supervisor: _____

Type of Work: _____
(Student Help-SH, College Work Study-CWS, Temp Clerical, or PT Inst., Job Title-if Regular Position)

Date Employed: _____ New Hire: ☐ OR New Assignment: ☐

If Applicable, previous Work Area (This applies to those already employed by Los Rios who have made a complete change. For example: A Custodian moving to College Police.):

A.	Was a Medical Questionnaire form completed? (If applicable to position for which hired)	☐ Yes	☐ No
B.	Has Employee taken pre-employment physical? (If applicable to position for which hired)	☐ Yes	☐ No
C.	Can you perform the essential functions of this position*? (Please contact HR at (916) 568-3112 if you require reasonable accommodation.)	☐ Yes	☐ No

*If answer to "C" is "No", please explain: _____

Please read the attached information and then answer the following:

I HAVE BEEN INFORMED OF THE FOLLOWING:

1.	District Safety Policies and Programs	☐ Yes	☐ No
2.	Safety rules, both general and specific to job	☐ Yes	☐ No
	2.1 How, when and where to report injuries	☐ Yes	☐ No
3.	Safety rule enforcement procedures	☐ Yes	☐ No
4.	Required and/or recommended personal protective equipment (i.e., shoes, gloves, etc.)	☐ Yes	☐ No
5.	Handling of materials related to position	☐ Yes	☐ No
6.	Importance of housekeeping	☐ Yes	☐ No
7.	Special hazards of job (see the Job Safety Analysis form)	☐ Yes	☐ No
8.	When and where to report unsafe conditions	☐ Yes	☐ No
9.	Safe operation of vehicle	☐ Yes	☐ No
10.	Asbestos Awareness	☐ Yes	☐ No
11.	Other (List specifics)_____	☐ Yes	☒ No

Employee Signature: _____ Date: _____

Hiring Representative Signature: _____ Date: _____

Note: Hiring Representative is to ensure that letters A-C are answered, numbers 1-10 are answered "yes", and #11 is answered.

NOTICE TO NEW EMPLOYEES

WORKERS' COMPENSATION

This form complies with Division 4, Chapter 2, Article 4, Section 3550 and 3551 of the California Labor Code.

If a work related injury or illness occurs, you are automatically entitled to Workers' Compensation benefits.

In the event of a work related injury or illness, you must notify your supervisor immediately!

You have a right to receive medical care at any of the facilities listed on the attached information sheet, and to receive temporary disability indemnity, permanent disability indemnity, vocational rehabilitation services, and death benefits (as appropriate). You may use a designated personal physician if you file the "Predesignation of Personal Physician" form prior to any injury.

The District is self-insured, and work related injuries are administered by York Insurance Services, P.O. Box 619058, Roseville, CA 95661-9058; telephone number (916) 960-0928.

Name of Employee: _____

Employee ID: _____

Signature: _____

Date: _____

Date of Hire: _____

Signature of Interviewer: _____

Original: Employee's Personnel File

LOS RIOS COMMUNITY COLLEGE DISTRICT
OPTIONAL
PRE-DESIGNATION OF PERSONAL PHYSICIAN

In the event you sustain an injury or illness related to your employment, you may be treated for such injury or illness by your personal medical doctor (M.D.), doctor of osteopathic medicine (D.O.) or medical group if:

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

You may use this form to notify your employer if you wish to have your personal medical doctor or a doctor of osteopathic medicine treat you for a work-related injury or illness and the above requirements are met.

NOTICE OF PRE-DESIGNATION OF PERSONAL PHYSICIAN
(Employee: Complete this section)

To: Los Rios Community College District (name of employer).
If I have a work-related injury or illness, I choose to be treated by: _____
(Name of Physician) (M.D., D.O., or medical group)

_____/_____
(Physician's street address, city, state, ZIP) (Physician's telephone number)

Employee Name:_____Employee ID# _____
(please print)

Employee's Address:_____

Name of insurance company, plan or fund providing health coverage for non-occupational injuries or illnesses:

_____

Employee's Signature:_____Dept: _____Location:_____ Date:_____
Status: ☐Faculty ☐Regular Classified ☐Temporary Classified ☐Student Help ☐ Manager

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Note to Employee: Unless an employee agrees, neither the employer nor the claims administrator shall contact your personal physician to confirm a pre-designation. If your physician does not sign the form, other documentation that they agreed to be pre-designated prior to the injury will be required. If you agree that after receiving this from your employer or claims administrator may contact your physician to confirm the pre-designation, sign below:

Employee's Signature:_____ Date:_____

Physician: I agree to this Pre-designation:

Signature:_____Date:_____
(Physician or Designated Employee of the Physician Medical Group)

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

Note to Physician: California workers' compensation medical services are subject to preauthorization of non- emergency services; utilization review; reporting requirements; and the California Official Medical Fee Schedule. The following optional information may assist communication and facilitate the authorization, reporting, recordkeeping and payment process:

Office Manager/Billing Contact:_____
Mailing Address (if different from street adress):_____
Phone:_____ Fax:_____ Email: _____

EMPLOYEES:*IF YOU CHOOSE TO COMPLETE THIS FORM, PLEASE RETURN THE COMPLETED FORM TO HUMAN RESOURCES AT THE DISTRICT OFFICE. REMEMBER: ALL work related injuries or illnesses must be reported to your Supervisor promptly.*

Original: Employee's Personnel File **Copy:** General Services Insurance file **Copy:** V.P. of Administration

I understand that this form is ONLY applicable IF and/or when I become a member of STRS or PARS.

Social Security Administration

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

Employee Name _____ **Employee ID#** _____

Employer Name Los Rios Community College District **Employer ID#** 1-941576340

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** _____

CalPERS

State of California
California Public Employees' Retirement System
www.calpers.ca.gov

Notice of Exclusion from CalPERS Membership

Public Agency and Schools

Your employer has contracted with the California Public Employees' Retirement System (CalPERS) to provide an employee benefit which includes service retirement, death, and disability benefits.

Section 1: Employee Information

Last Name	First	Middle	DOB	CID

Section 2: Employer Information

Name of Department	Division	Position Title
		Classfied Temporary

Term of Appointment: ☐ **Permanent** ☑ **Temporary**

If Temporary, enter nearest number of whole months the appointment is expected to last: **Months** **Appointment Date**

Time Base: ☐ **Full Time** ☐ **Intermittent**
☐ **Indeterminate** ☑ **Part Time** if part time enter the fraction of full time:

In your current position with this agency, you are excluded from CalPERS membership because:

1. ☐ Your full time seasonal or limited term appointment is limited to six months or less.
2. ☐ Your part time appointment is limited to less than an average of 20 hours per week for less than one year.
3. ☑ Your appointment is an on call, intermittent, emergency, substitute, or other irregular basis which excludes you from membership until you have worked 1,000 hours (or 125 days if paid on per diem basis) in a fiscal year (July 1-June 30).
4. ☐ Your position is excluded by law. Explain the exclusion that applies below:

5. ☐ You are an independent contractor.
6. ☐ You are employed to render professional legal service to a city. Exceptions include persons holding the office of city attorney, deputy city attorney, or assistant city attorney.
7. ☐ You are employed as a student assistant by a school district in a position established for students only while attending school in the same district. (This only applies to County Schools.)
8. ☐ You are a CalPERS retiree and have not reinstated from retirement.
   Note: If you are a CalPERS member from previous employment and have not terminated membership (taken a refund of your contributions and service credit) exclusions 1, 2, and 3 do not apply to you. You should qualify for membership immediately in your current position. Please notify your employer to complete your enrollment and report your employment to CalPERS.

If you believe your employment does qualify you for CalPERS membership, ask your employer to provide you with an explanation. You can also contact CalPERS directly by sending a letter that provides the reasons why you feel you should be a member to the Employer Account Management Division, P.O. Box 942709, Sacramento, CA 94229-2709

Signature of Certifying Officer	**Title**	**Date**

Signature of Employee	**Date**

Note: Information regarding the benefits provided by CalPERS is available on the CalPERS website www.calpers.ca.gov.

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

CalPERS Privacy Notice

Privacy Notice
The privacy of personal information is of the utmost importance to CalPERS. The following information is provided to you in compliance with the Information Practices Act of 1977 and the Federal Privacy Act of 1974.

Information Purpose
The information requested is collected pursuant to the Government Code (sections 20000 et seq.) and will be used to conduct CalPERS Board of Administration duties under the Public Employees' Retirement Law, the Social Security Act, and/or the Public Employees' Medical and Hospital Care Act, as the case may be. Submission of the requested information is mandatory. Failure to submit the required information may result in CalPERS being unable to perform its functions regarding your status.

Please do not include information that is not requested.

Social Security Numbers
Social Security numbers are collected either on a mandatory or voluntary basis. If this is CalPERS' first request for disclosure of your Social Security number, then disclosure is mandatory. If your Social Security number has already been provided, disclosure is voluntary. Due to the use of Social Security numbers by other agencies for identification purposes, we may be unable to verify eligibility for benefits without the number.

1. Social Security numbers are used for the following purposes:
2. Enrollee identification
3. Payroll deduction/state contributions
4. Billing of contracting agencies for employee/employer contributions
5. Reports to CalPERS and other state agencies
6. Coordination of benefits among carriers
7. Resolving member appeals, complaints, or grievances with health plan carriers

Information Disclosure
Portions of this information may be transferred to other state agencies (such as your employer), physicians, and insurance carriers, but only in strict accordance with current statutes regarding confidentiality.

Your Rights
You have the right to review your membership files maintained by CalPERS. For questions about this notice, our Privacy Policy, or your rights, write to:

CalPERS
CalPERS Privacy Officer
400 Q Street
Sacramento, CA 95811

You may also call us at **888 CalPERS** (or **888**-225-7377).

EMPLOYEE FERPA AGREEMENT

(Family Education Rights and Privacy Act)

I understand that by virtue of my employment with Los Rios Community College District, I may have access to records that contain individually identifiable information about a student, the disclosure of which is prohibited by the Family Educational Rights and Privacy Act of 1974 (FERPA).

Student records are highly confidential and all employees are expected to abide by FERPA as well as general confidentiality practices. In order to ensure that student record information is protected, you are asked to review the following and sign below:

- Access to student information is limited to employees with approved security access. Requests from others for a student's phone number, address, or other protected information should be directed to a lead staff member or supervisor.
- Social security numbers are to be protected at all times. At no time should you provide someone with his/her social security number or a document with that number printed on it unless a valid photo ID is provided.
- All documents with any personal identification information must be destroyed properly (shredding bin or shredder).
- Access to student information is for the purpose of conducting the business of the Colleges and District. Information on a student may not be accessed for any other reason nor shared with anyone for any other purpose.
- No student information (including your own) may be altered without using standard procedures (completing forms, having a staff member enter the information in the system).
- No employee shall knowingly include or cause to be included in any student record or report a false, inaccurate or misleading entry.
- At no time should confidential student information be given out over the phone or faxed.
- Please ensure that confidential information is not left out in the open within view of students.

While your supervisor can assist you in understanding these laws and LRCCD's policies, you should become familiar with them, particularly those regarding required consent to release information, the list of information which can be released for currently enrolled students without consent, and how information is designated when the student has indicated that it cannot be released. A short information sheet is located here: http://www.losrios.edu/legal/FERPATips.pdf

When a student has chosen to indicate information about them is not to be released, the requestor should be advised "that we are unable to release any information" and be given no indication of whether or not you may have any information on the person. You are advised to refer any questions or requests for information that you are unsure of to your supervisor.

I acknowledge that I fully understand that the intentional disclosure by me of this information to any unauthorized person violates federal law, state law and Los Rios Community College District's policy and could constitute just cause for disciplinary action including termination of my employment regardless of whether criminal or civil penalties are imposed. I have retained in my possession a copy of the document for future reference.

Last Name, First Name (Please Print or Type) _____ Employee ID# OR Last 4 digits of SSN _____

Employee Signature _____ Date _____

ORIGINAL: HUMAN RESOURCES COPY: EMPLOYEE

Revised: 3/2018
Form#: S-1

Designation of Beneficiary Form
Public Agency Retirement Services (PARS)

Instructions:

1. Read carefully the rules for designating a beneficiary below, and sign in the spaces provided.
2. Complete the appropriate sections (Section 1 must be completed, see rules below regarding Section 2) of this form and return it to:

Los Rios Community College District
Attn: Human Resources Department
1919 Spanos Court
Sacramento, CA 95825

Rules for Designation of Beneficiary:

1. It is your responsibility to keep your Designation of Beneficiary current.
2. You reserve the right to revoke or change your Designation of Beneficiary, subject to the other provisions of these Rules.
3. If, upon your death, there is no valid Designation of Beneficiary on file with the Trust Administrator, any death benefits which become due will be paid in accordance with the Plan Document.
4. The plan requires that if you are married, your surviving spouse/registered domestic partner will be your sole primary beneficiary, unless your spouse/registered domestic partner waives this right.
5. If you wish to designate a person or persons other than your spouse/registered domestic partner or in addition to your spouse/registered domestic partner, you must obtain the notarized consent of your spouse/registered domestic partner in writing on this form by completing Section 2. Failure to obtain your spouse/registered domestic partner's consent in these instances will render the designation invalid. Any consent by a spouse/registered domestic partner applies only to that spouse/registered domestic partner and not any future spouse/registered domestic partner. Therefore, if a new marriage occurs, a new Designation of Beneficiary form should be completed and the new spouse/registered domestic partner's consent must be obtained. If you are unmarried complete Section 1 only.
6. If the location of your spouse/registered domestic partner is unknown, you must attach to this form a notarized statement stating that your spouse/registered domestic partner cannot be located.
7. You are considered married if you are under decree of separate maintenance or decree of legal separation.
8. If you wish to have your PARS account distributed under the terms of a Living Trust, your PARS account must be mentioned by name in the Trust Document. If your current Living Trust does not contain specific reference to your PARS account, you may designate the Living Trust as a beneficiary using this form. All rules pertaining to the designation of a beneficiary apply to the designation of a Living Trust.

I have read and understand these rules.

_____ _____
Participant's Signature **Date**

Section 1: Designating a Beneficiary

Participant Name: _____ Social Security # _____ - _____ - _____

Participant Address: _____

City : _____ State: _____ Zip: _____ Phone #: _____

Name of Beneficiary: _____ Relationship: _____

Beneficiary Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

_____ _____
Participant's Signature **Date**

Section 2: Spousal/Registered Domestic Partner Consent *(Do not complete this section if you are unmarried)*

I hereby consent to the above beneficiary designation of my spouse/registered domestic partner, a participant in this plan. I understand that in consenting to the designation of anyone except myself, I am waiving rights to a survivor benefit that I would be legally entitled to at a later date.

_____ _____
Spouse/Registered Domestic Partner's Signature **Date**

_____ _____
Signature of Notary **Date**

Los Rios Community College District

Demographic Survey

(Confidential Use Only)

The Los Rios Community College District (LRCCD) requests your assistance in our efforts to comply with State and Federal reporting guidelines. These guidelines allow employees to select multiple ethnicities with which they identify to more accurately reflect the ethnic heritage of the LRCCD population. Please complete the survey below. A Q & A on this topic is printed on the back of this form for your reference, or you may call the Human Resources Department at (916) 568-3112 with any additional questions.

Employee Name: (Please print) _____

Employee ID # or last 4 digits of Social Security Number: _____

Are you Hispanic or Latino? (Check one) ☐ **Yes** **or** ☐ **No**

What is your race/ethnicity? (Check one or more)

- ☐ **American Indian/Alaskan**
- ☐ **Asian Indian**
- ☐ **Black/African American**
- ☐ **Cambodian**
- ☐ **Central American**
- ☐ **Chinese**
- ☐ **Filipino**
- ☐ **Guamanian**
- ☐ **Hawaiian**
- ☐ **Japanese**
- ☐ **Korean**
- ☐ **Laotian**
- ☐ **Mexican, Mexican American, Chicano**
- ☐ **Samoan**
- ☐ **South American**
- ☐ **Vietnamese**
- ☐ **White**
- ☐ **Other Asian**
- ☐ **Other Hispanic**
- ☐ **Other Pacific Islander**

Are you disabled? (Check one) ☐ **Yes** **or** ☐ **No**

The Los Rios Community District is committed to complying with the Americans with Disabilities Act. Should you need to request accommodations for a disability please contact the Human Resources office at (916) 568-3112 or visit this website for more information: http://www.losrios.edu/legal/faq2.php

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What is your gender identity? (Check one) ☐ **Female** ☐ **Male** ☐ **Non-Binary**

Employee Signature: _____ **Date:** _____

Revised: 08/18

Employment Eligibility Verification

Department of Homeland Security

U.S. Citizenship and Immigration Services

USCIS Form I-9

OMB No.1615-0047

Expires 07/31/2026

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Additional Information

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

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

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

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

Employer's Business or Organization Name	Employer's Business or Organization Address, City or Town, State, ZIP Code

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 07/31/2026

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

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

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

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

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

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

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

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

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

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

Supplement B,

Reverification and Rehire (formerly Section 3)

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

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

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

Instructions: This supplement 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.

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

(Required by Chapter 8, Division 4, Title I of Government Code)

State of California)
ss
County of Sacramento)

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.

I declare, under penalty of perjury, that the foregoing is true and correct.

_____ _____ _____
Signature Date Place (City)

OR

I decline to sign the oath of allegiance because it is contrary to my religious beliefs.

_____ _____ _____
Signature Date Place (City)

Los Rios Community College District
Statement of Mandated Reporter

Child Abuse and Neglect Reporting Law (Penal Code, § 11166.5) Definitions: The following situations involving minors (minors are individuals under 18 years of age) are reportable child abuse and neglect conditions (report if the abuse/condition took place when the individual was under 18 years of age, even if the individual is no longer under 18 years of age):

1) Physical abuse
2) Sexual abuse
3) Child exploitation, child pornography and child prostitution
4) Severe or general neglect
5) Extreme corporal punishment resulting in injury
6) Willful cruelty or unjustifiable punishment
7) Abuse or neglect in out-of-home care

Who must Report: Any employee/volunteer whose duties/tasks bring them into contact with minors on a regular basis or any supervisor of such an employee is a mandated reporter effective January 1, 2013. This includes nearly all Los Rios employees, including all Coaches and Assistant Coaches.

When to Report: Employees/Volunteers must make a telephone report immediately when the employee/volunteer observes a minor in his/her professional capacity or within the scope of his/her employment/volunteerism and has knowledge of, or has reasonable suspicion that the minor has been abused. The employee/volunteer must submit a written report, on a standard form, within 36 hours after the telephone report has been made. This includes if the abuse/condition took place when the individual was under 18 years of age, even if the individual is no longer under 18 years of age

To Whom Do You Report: Employees/Volunteers should report to the Los Rios Police Department at (916) 558-2221. Alternatively, employees/volunteers may report to the local Police, Sheriff, the Probation Department, or any Child Welfare Agency.

Reporting: Mandated reporters are required to give their names. Child protective agencies are required to keep the mandated reporter's name confidential, unless a court orders the information disclosed.

Immunity: Any legally mandated reporter has immunity when making a report. In the event a civil suit is filed against the reporter, the state will reimburse attorney fees incurred up to $50,000 (Penal Code, § 11172). In addition, the Los Rios Community College District will pay for any mandated reporters' attorney fees or judgment arising out of any report made in good faith in the course and scope of employment. No individual can be dismissed, disciplined or harassed for making a good faith report of suspected child abuse.

Liability: Legally mandated reporters may be criminally liable for failing to report suspected abuse. The penalty for this misdemeanor is up to six months in county jail, a fine of not more than $1,000 or both. Mandated reporters can also be civilly liable for failure to report.

Notification Regarding Abuse: You are not legally required to notify the parents that you are making a report.

Information: Additional information and training is available through the California Department of Social Services at mandatedreporterca.com/training/school-personnel (please note this training is optional and takes 90 to 180 minutes). Further information is also available at the Los Rios Employees website at employees.losrios.edu/mandated-reporter. For questions regarding this form or assistance needs to access any of these trainings, please contact the Human Resources Office at 916-568-3112.

Employee: I understand as an Employee that I am a legally mandated reporter. I have reviewed the information above about my obligations to report Child Abuse and Neglect under Penal Code 11166 and will comply with those requirements.

Check Appropriate Employee Type:

☐ Adjunct Faculty ☐ Full-Time Faculty ☐ Employment Service Agreement ☐ Professional Expert Agreement
☐ Regular Classified ☐ Student Employee ☐ Management ☐ Temporary Classified

Volunteer: I understand as a Volunteer that although I may not be legally obligated to report abuse/neglect, that the District and the College strongly encourages me to do so. ☐ Volunteer

_____	_____	_____	_____
Employee's Name (Print)	*Signature*	*Employee/Student ID (if known)*	*Date*

_____	_____	_____
Supervisor/Witness Name (Print)	*Signature*	*Date*

EMPLOYEE DISTRIBUTION: Original is forwarded to District Office, Human Resources. Provide a copy to employee upon their request.
VOLUNTEER DISTRIBUTION: Original is forwarded to the College Vice President of Administration Office. Provide a copy to volunteer upon their request.

STATE OF CALIFORNIA
BCIA 8016
(orig. 04/2001; rev. 01/2011)

DEPARTMENT OF JUSTICE

REQUEST FOR LIVE SCAN SERVICE

Applicant Submission

A0743
ORI (Code assigned by DOJ)

Employment
Authorized Applicant Type

Temporary Classified
Type of License/Certification/Permit OR Working Title (Maximum 30 characters - if assigned by DOJ, use exact title assigned)

Contributing Agency Information:

Los Rios Community College District
Agency Authorized to Receive Criminal Record Information

02175
Mail Code (five-digit code assigned by DOJ)

1919 Spanos Court
Street Address or P.O. Box

Chanelle Whittaker
Contact Name (mandatory for all school submissions)

Sacramento | CA | 95825
City | State | ZIP Code

(916) 568-3112
Contact Telephone Number

Applicant Information:

X
Last Name

X
First Name | Middle Initial | Suffix

Other Name (AKA or Alias) X
Last

X
First | Suffix

X
Date of Birth

Sex ☐ Male ☐ Female

X
Driver's License Number

X Height | X Weight | X Eye Color | X Hair Color

Billing Number 130190
(Agency Billing Number)

X
Place of Birth (State or Country)

Social Security Number

Misc. Number
(Other Identification Number)

Home Address X
Street Address or P.O. Box

X
City | State | ZIP Code

Your Number:
OCA Number (Agency Identifying Number)

Level of Service: ☒ DOJ ☐ FBI

If re-submission, list original ATI number:
(Must provide proof of rejection)

Original ATI Number

Employer (Additional response for agencies specified by statute):

Employer Name

Mail Code (five digit code assigned by DOJ)

Street Address or P.O. Box

City | State | ZIP Code

Telephone Number (optional)

Live Scan Transaction Completed By:

Name of Operator

Date

Transmitting Agency | LSID | ATI Number | Amount Collected/Billed

ORIGINAL - Live Scan Operator | SECOND COPY - Applicant | THIRD COPY (if needed) - Requesting Agency

LOS RIOS COMMUNITY COLLEGE DISTRICT

1919 SPANOS COURT SACRAMENTO, CA 95825-3981

Name (please print): _____

Employee ID or Social Security Number: _____

I authorize the Los Rios Community College District to deduct $32.00 for a background check conducted by the Department of Justice. I understand this amount will be deducted from my first paycheck.

_____ _____

Signature *Date*

_____ _____

Campus *Department*

PO237
GS Form #34
Revised: 6/6/03