

CONEJO VALLEY UNIFIED SCHOOL DISTRICT
PERSONNEL SERVICES DIVISION
1400 E. Janss Road, Thousand Oaks, California 91362
Telephone (805) 497-9511 · FAX (805) 494-3741

PERSONAL INFORMATION FORM

☐

NEW EMPLOYEE

☐

CHANGE REQUEST—SPECIFY REQUEST TYPE BELOW:

☐

Legal name change - Must have new Social Security Card and Picture ID prior to change

☐

Address change

☐

Emergency contact change

1. EMPLOYEE LEGAL NAME:

Last Name

First Name

Middle Initial

Specify former legal name, if requesting name change: _____

XXXX - XX - _____

Social Security No. (Last 4 digits)

2. EMPLOYEE OFFICIAL ADDRESS AND CONTACT INFORMATION:

Street

Unit/Apartment

City

State

Zip Code

Home Phone #: (_____)_____ - _____

Cell #: (_____)_____ - _____

Email _____

3. EMERGENCY CONTACT INFORMATION

Last Name

First Name

Relationship

Street

Unit/Apartment

City

State

Zip Code

Home Phone #: (_____)_____ - _____

Cell #: (_____)_____ - _____

Email _____

4. EMPLOYEE CERTIFICATION

Signature

Date



CONEJO VALLEY UNIFIED SCHOOL DISTRICT
HUMAN RESOURCES DEPARTMENT
1400 E. Janss Road, Thousand Oaks, California 91362
Telephone (805) 497-9511 • FAX (805) 494-3741

NOTICE OF PRE-DESIGNATION OF PERSONAL PHYSICIAN

Employee Last Name _____ First Name _____ Middle Initial _____ Suffix _____
XXX - XX - _____
Social Security # (last 4) _____ Date of Birth (MM/DD/YYYY) _____ Position _____

EMPLOYEE ACKNOWLEDGEMENT OF NON-ELECTION OF PREDESIGNATED PERSONAL PHYSICIAN

I acknowledge receipt of this form and elect not to pre-designate my personal physician at this time. I understand that, at anytime 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 with the District prior to an industrial injury.

Employee Signature _____ Date _____

I: EMPLOYEE - COMPLETE THIS SECTION TO REQUEST PREDESIGNATION OF PERSONAL PHYSICIAN:

INSTRUCTIONS: 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.) or doctor of osteopathic medicine (D.O.) if:

1. Your employer offers group health coverage;
2. 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;
3. Your "personal physician" may be a medical group if it is a single corporation or partnership composed of licensed doctors of medicine or osteopathy, which operates an integrated multispecialty medical group providing comprehensive medical services predominantly for non-occupational illnesses and injuries;
4. Prior to the injury your doctor agrees to treat you for work injuries or illnesses;
5. Prior to the injury you provided CVUSD (employer) the following notice in writing:
(1) notice that you want your personal doctor to treat you for a work-related injury or illness, and (2) your personal doctor's name and business address.

**** COMPLETION OF THE INFORMATION BELOW WILL SATISFY THE NOTICE REQUIREMENT ****

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

_____, at
Name of Physician (M.D., D.O.) or Medical Group (please print)

Physician Street Address City State Zip

The above physician is my personal physician who has previously directed my medical care and retains my medical history and records.

I understand that I am responsible for signing the document below and seeking agreement and signature from my personal physician. I understand that **the completed document MUST be returned to the CVUSD Human Resources Department** prior to a work-related injury or illness, otherwise my request for pre-designation is not valid. I further understand that the physician is not required to sign this form, however, if the physician or designated employee of the physician 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).

Employee Signature _____ Date _____

II: PHYSICIAN - COMPLETE SECTION BELOW TO ACCEPT THE PRE-DESIGNATION:

I agree to treat the above named individual should they have a work injury or illness. I understand that medical services are subject to preauthorization of non-emergency services and diagnostic tests, utilization review, reporting requirements, and fees are governed by the Official Medical Fee Schedule promulgated by the Division of Workers' Compensation.

Physician Name (please print) _____ Phone Number _____

Physician Signature _____ Date: _____



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WARRANT RECIPIENT DESIGNATION

NOTICE TO EMPLOYEE: Legal restrictions prohibit the District from releasing checks or warrants to another person in case of an employee's death unless a designation has been made in accordance with Government Code 53245.¹

You may elect to designate a warrant recipient by completing this form, so that the designated person may immediately receive paychecks, or other monies, which may be owed to you. Please complete only the bottom portion if you do not wish to designate a warrant recipient at this time.

I, _____, am an employee of the Conejo Valley Unified School District. Pursuant to the provisions of Government Code, Section 53245, in the event of death, I hereby designate the person named below as the one entitled to receive any and all warrants or checks which would have been payable to me by the District had I survived. This designation hereby revokes and stands in place of any and all other previous designations.

It is expressly understood and agreed that the Conejo Valley Unified School District is not obligated to deliver said warrant(s) to the person designated above unless the designated person, within two years after the date of said warrant(s) claims such warrant (s) from the Conejo Valley Unified School District and provides sufficient proof of identity.

DESIGNATED PERSON'S LEGAL NAME: _____

ADDRESS: _____
Street City State Zip

RELATIONSHIP: _____ CONTACT #: _____

Employee Signature Date

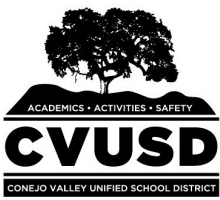
*****PLEASE COMPLETE BELOW IF NOT DESIGNATING A WARRANT RECIPIENT*****

I, _____, do not wish to designate any person to receive warrants pursuant to Government Code Section 53245.

Signature Date

REFERENCE: GOVERNMENT CODE – STATE OF CALIFORNIA

§ 53245. Any person now or hereafter employed by a county, city, municipal corporation, district, or other public agency may file with his appointing power a designation of a person who, notwithstanding any other provision of law, shall, on the death of the employee, be entitled to receive all warrants or checks that would have been payable to the decedent had he survived. The employee may change the designation from time to time. A person so designated shall claim such warrants or checks from the appointing power. On sufficient proof of identity, the appointing power shall deliver the warrants or checks to the claimant. A person who receives a warrant or check pursuant to this section is entitled to negotiate it as if he were the payee.



Shauna Ashmore
Assistant Superintendent, Human Resources

OATH or AFFIRMATION OF ALLEGIANCE

DISCLAIMER: This form is required by Section 3 of Article XX of the Constitution of the State of California. By subscribing to the oath or affirmation set forth in the California Constitution you take on the designation of being a disaster service worker in time of need, as is required of all public employees. (California Government Code 3100-3109).

"I, _____
First Name Middle Name Last Name Suffix

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 will 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 certify (or declare) under penalty of perjury that the foregoing is true and correct.

_____ at _____ am / pm.
(date) (time)

City State

Signature



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EMPLOYEE ACCEPTABLE TECHNOLOGY USE AGREEMENT

**THE USE OF THE NETWORK, DISTRICT TECHNOLOGY, AND DISTRICT
ELECTRONIC RESOURCES ARE A PRIVILEGE AND NOT A RIGHT.**

The Conejo Valley Unified School District makes no warranties of any kind, whether expressed or implied, for the availability of technology resources. The District will not be responsible for any information that may be lost, damaged, or unavailable due to technical or other difficulties. The District cannot ensure that all electronic transmissions are secure and private and cannot guarantee the accuracy or quality of information obtained. The District will employ technology protection measures to comply with Federal and State requirements to filter or block material defined to be objectionable. However, no known process can control or censor all illegal, defamatory, or potentially offensive materials that may be available to the user on systems accessible through the technology resources of the Conejo Valley Unified School District.

Use of technology resources or transmission of any material in violation of any federal or state law is strictly prohibited. Also prohibited is the use or transmission of material protected by federal or state intellectual property laws; copyrighted material; licensed material; threatening, harassing, obscene material and/or pornographic material. In addition, users are prohibited from accessing or attempting to access, using or attempting to use, the Internet or other computer network or non-network facilities for any other unauthorized purposes. This includes but is not limited to commercial activities, introduction of viruses, and manipulation or corruption of systems, files and other related resources. Any illegal activities will be reported to the appropriate agencies.

I have read, understand, and agree to abide by the terms of this Agreement and the related Administrative Regulation, AR 4040 - Employee Use of Technology. I accept responsibility for the appropriate use of the CVUSD computer resources, which include all computer systems, network systems, Internet and intranet web sites or other data processing equipment owned or leased by the CVUSD, as well as remote computers, or computer systems when used to access CVUSD computer resources, the phone system including voice mail, cell phones and office equipment. Should I commit any violation or in any way misuse my access to the CVUSD computer network and the Internet, I understand that my access privilege may be revoked and disciplinary action may be taken against me.

Print Name

Signature

Date



WORKERS' COMPENSATION BENEFITS

NOTICE TO NEW EMPLOYEE — YOU ARE HEREBY INFORMED OF THE FOLLOWING:

- You are covered under the District's workers' compensation insurance for any injury or illness that is deemed to be job related from your first day of employment. In the event that you are injured at work, you should report your injury to your supervisor immediately. For additional information, please contact Risk Management at (805) 498-4557, ext.7527 or email at riskmanagement@conejousd.org.
- All work related injuries must be reported to the Company Nurse 24 hour injury reporting service: 855-602-5267 using company code VCS11. The Company Nurse representative will assist you with the beginning of the workers' compensation claim process and direct you to an authorized medical care provider for evaluation and treatment.
- The Conejo Valley Unified School District also offers medical insurance benefits to cover non-industrial illnesses and injuries for those permanent classified and certificated employees that are eligible for medical coverage.
- All permanent classified and certificated employees under contract are entitled to illness leave for both industrial and non-industrial injury or illness.
- PLEASE NOTE:** CONEJO VALLEY UNIFIED SCHOOL DISTRICT IS NOT COVERED BY THE CALIFORNIA STATE DISABILITY INSURANCE PROGRAM.

EMPLOYEE ACKNOWLEDGEMENT OF RECEIPT OF WORKERS' COMPENSATION DOCUMENTS

I certify that I have read the above and I have read through the following Workers' Compensation Benefits information documents posted online:

<u>INITIALS</u>	<u>DOCUMENT NAME</u>
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_____	LWP Claims Platinum MPN
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_____	CVUSD Annual Plan Open Enrollment Legal Notices
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_____	Employee Pre-designation of Personal Physician for Work Related Injuries Completed form (requires physician signed consent to treat work-related injury/illness) must be returned to Classified or Certificated Human Resources Department to be valid at the time of work-related injury/illness.
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_____	Reporting Workplace Injuries
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Signature

Date



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HEALTH STATUS QUESTIONNAIRE

INSTRUCTIONS: **Please print or type and ensure all information is provided as omissions may delay processing.**

1. PERSONAL INFORMATION:

Last Name First Name Middle Suffix

Date of Birth (MM/DD/YYYY) Title of Position Applied For:

2. NOTICE TO THE EMPLOYEE:

Please read the Conejo Valley Unified School District policy, answer the questions below, and sign this statement. This form will become a part of your personnel file and may be used should any disciplinary action be required because of your ability to complete the duties of your job based on a pre-existing physical condition.

POLICY:

The health requirements for new employees and employees in service shall be based upon the employee's physical, mental, and emotional ability to perform all the duties of the assignment satisfactorily without endangering his/her health or safety or the health and safety of other employees and students.

1. Do you possess any physical, mental, and/or emotional ability limitations which would prohibit you from carrying out duties which are typical of those for the position for which you are applying?

☐

No

☐

Yes, Explain: _____

2. Have you presently applied for or are you now receiving payments from a worker's compensation claim?

☐

No

☐

Yes, Explain: _____

3. EMPLOYEE CERTIFICATION OF HEALTH STATUS PRIOR TO EMPLOYMENT:

I certify (or declare) under penalty of perjury that the foregoing is true and correct.

Signature

Date



Nondiscrimination in Employment Administrative Regulations (AR) 4030

All allegations of discrimination in employment, including those involving an employee, job applicant, intern, volunteer, or other person contracted to provide services to the district shall be investigated and resolved in accordance with procedures specified in this administrative regulation.

The district designates the position identified below as its coordinator for nondiscrimination in employment (coordinator) to organize and manage the district's efforts to comply with state and federal nondiscrimination laws and to answer inquiries regarding the district's nondiscrimination policies. The coordinator may be contacted at:

Assistant Superintendent, Human Resources
Conejo Valley Unified School District
750 Mitchell Road
Newbury Park, CA 91320
805-498-4557 Ext. 7402

Measures to Prevent Discrimination

To prevent unlawful discrimination, harassment, and retaliation in district employment, the Superintendent or designee shall implement the following measures:

1. Display in a prominent and accessible location at every work site where the district has employees, and post electronically in a conspicuous location on computers for employee use, up-to-date California Civil Rights Department (CRD) posters on the prohibition of workplace discrimination and harassment, the rights of transgender employees, and the rights and obligations of employees who are pregnant, have a related medical condition, or are recovering from childbirth (Government Code 12950; 2 CCR 11013, 11023, 11049) "
2. Publicize the district's nondiscrimination policy and regulation, including the complaint procedures and the coordinator's contact information, by: (5 CCR 4960; 34 CFR 100.6, 106.8)
 - a. Including them in each announcement, bulletin, or application form that is used in employee recruitment
 - b. Posting them in all district schools and offices, including staff lounges and other prominent locations
 - c. Posting them on the district's web site and providing easy access to them through district-supported social media, when available
3. Disseminate the district's nondiscrimination policy and administrative regulation to all employees by one or more of the following methods: (2 CCR 11023)

- a. Printing and providing a copy to all employees, with an acknowledgment form for each employee to sign and return
 - b. Sending a copy via email with an acknowledgment return form
 - c. Posting a copy on the district intranet with a tracking system ensuring all employees have read and acknowledged receipt of the policies
 - d. Discussing the policy and regulation with employees upon hire and/or during a new hire orientation session
 - e. Any other way that ensures employees receive and understand the policy
4. Provide to employees a handbook which contains information that clearly describes the district's nondiscrimination policy, procedures for filing a complaint, and resources available to employees who believe they have been the victim of any discriminatory or harassing behavior
5. Provide training regarding the district's nondiscrimination policy, including what constitutes unlawful discrimination, harassment, and retaliation and how and to whom a report of an incident should be made

The district may also provide bystander intervention training to employees which includes information and practical guidance on how to recognize potentially problematic behaviors and which may motivate them to take action when they observe such behaviors. The training and education may include exercises to provide employees with the skills and confidence to intervene as appropriate and to provide them with resources they can call upon that support their intervention. (Government Code 12950.2)

6. Periodically review the district's recruitment, hiring, and promotion processes and regularly monitor the terms, conditions, and privileges of employment to ensure district compliance with law
7. For any district facility where 10 percent of employees have a language other than English as their spoken language, translate the policy into every language spoken by at least 10 percent of the workforce (2 CCR 11023)

Complaint Procedure

Complaints of sexual harassment shall be investigated and resolved in accordance with AR 4119.12/4219.12/4319.12 - Title IX Sexual Harassment Complaint Procedures if the alleged conduct meets the definition of sexual harassment pursuant to 34 CFR 106.30.

Any other complaint alleging unlawful discrimination or harassment shall be addressed in accordance with the following procedures:

1. Notice and Receipt of Complaint: A complainant may inform a direct supervisor, another supervisor, the coordinator, the Superintendent or, if available, a complaint hotline or an ombudsman. The complainant's direct supervisor may be bypassed in filing a complaint when the supervisor is the subject of the complaint.

The complainant may first attempt to resolve the situation informally with the complainant's supervisor before filing a written complaint.

A supervisor or manager who has received information about an incident of discrimination or harassment, or has observed such an incident, shall report it to the coordinator, whether or not the complainant files a written complaint.

The written complaint should contain the complainant's name, the name of the individual who allegedly committed the act, a description of the incident, the date and location where the incident occurred, any witnesses who may have relevant information, any available evidence of the discrimination or harassment, and any other pertinent information which may assist in investigating and resolving the complaint.

2. Investigation Process: The coordinator shall initiate an impartial investigation of an allegation of discrimination or harassment within five business days of receiving notice of the alleged discriminatory or harassing behavior, regardless of whether a written complaint has been filed or whether the written complaint is complete.

The coordinator shall meet with the complainant to describe the district's complaint procedure and discuss the actions being sought by the complainant in response to the allegation. The coordinator shall inform the complainant that the investigation of the allegations will be fair, timely, and thorough and will be conducted in a manner that provides all parties due process and reaches reasonable conclusions based on the evidence collected. The coordinator shall also inform the parties that the investigation will be kept confidential to the extent possible, but that some information may be disclosed as necessary to conduct an effective investigation.

If the coordinator determines that a detailed fact-finding investigation is necessary, the investigation shall begin immediately. As part of this investigation, the coordinator should interview the complainant, the person accused, and other persons who could be expected to have relevant information.

The coordinator shall track and document the progress of the investigation to ensure reasonable progress and shall inform the parties as necessary.

When necessary to carry out the investigation or to protect employee safety, the coordinator may discuss the complaint with the Superintendent or designee, district legal counsel, or the district's risk manager.

The coordinator shall also determine whether interim measures, such as scheduling changes, transfers, or leaves, need to be taken before the investigation is completed in order to prevent further incidents. The coordinator shall ensure that such interim measures do not constitute retaliation.

3. Written Report on Findings and Remedial/Corrective Action: No more than 20 business days after receiving the complaint, the coordinator shall conclude the investigation and prepare a written report of the findings. This timeline may be extended for good cause. If an extension is needed, the coordinator shall notify the

parties and explain the reasons for the extension.

The report shall include the decision and the reasons for the decision and shall summarize the steps taken during the investigation. If a determination has been made that discrimination or harassment occurred, the report shall also include any corrective action(s) that have been or will be taken to address the behavior, provide appropriate options for remedial actions and resolutions for the complainant, and ensure that retaliation or further discrimination or harassment is prevented. The report shall be presented to the Superintendent or designee.

A summary of the findings shall be presented to the complainant and the person accused.

4. Appeal to the Governing Board: The complainant or the person accused may appeal any findings to the Board within 10 business days of receiving the written report of the coordinator's findings. The Superintendent or designee shall provide the Board with all information presented during the investigation. Upon receiving an appeal, the Board shall schedule a hearing as soon as practicable. Any complaint against a district employee shall be addressed in closed session in accordance with law. The Board shall render its decision within 10 business days.

Other Remedies

In addition to filing a discrimination or harassment complaint with the district, a person may file a complaint with either CRD or the Equal Employment Opportunity Commission (EEOC). The time limits for filing such complaints are as follows:

1. For filing a complaint with CRD alleging a violation of Government Code 12940-12952, within three years of the alleged discriminatory act(s), unless an exception exists pursuant to Government Code 12960 (Government Code 12960)
2. For filing a complaint with EEOC, within 180 days of the alleged discriminatory act(s) (42 USC 2000e-5)
3. For filing a complaint with EEOC after first filing a complaint with CRD, within 300 days of the alleged discriminatory act(s) or within 30 days after the termination of proceedings by CRD, whichever is earlier (42 USC 2000e-5)

I have read the Nondiscrimination in Employment Board Policy BP4030 and Administrative Regulation AR4030.

Employee's Name: _____

Signature: _____ Date: _____

Note: An original signed version of this Acknowledgement will be maintained in the employee's personnel file.

ACKNOWLEDGEMENT OF MANDATED REPORTER STATUS AND LEGAL DUTY TO REPORT CHILD ABUSE AND NEGLECT

California law requires certain people to report known or suspected child abuse or neglect. Based on your position and responsibilities as an employee of Conejo Valley Unified School District, you are such a person, known in the law as a “mandated reporter.” The law requires that you, as a mandated reporter, sign this statement that you know your legal reporting obligations, summarized below, and will comply with them.

The definition of mandated reported (Penal Code § 11165.7), along with the law describing your reporting obligations (Penal Code § 11166) and the law describing the content of reports and the confidentiality of those who report (Penal Code § 11167) is provided as an attachment to this form.

WHEN REPORTING ABUSE IS REQUIRED

As a mandated reporter, whenever in your professional capacity or within the scope of your employment you have knowledge of or observe a person under the age of 18 years whom you know or reasonably suspect has been the victim of child abuse or neglect, you must report the suspected incident (Penal Code §11166).

PROCEDURE FOR REPORTING

To make a report, you must use the following procedure:

- Immediately, or as soon as practically possible, contact the appropriate agency by telephone.
- With 36 hours of receiving the information concerning the incident, prepare a written report using the form provided in Attachment C and send, fax, or electronically transmit the report to the appropriate agency (Penal Code § 11166).

If assistance is needed in the completion of the form, your supervisor, school counselor, or Human Resources can assist you in filling out the form.

You are encouraged, but not required, to also report the suspected child abuse or neglect to your supervisor. Reporting to a supervisor, a coworker, or other person shall not be a substitute for making a mandated report to the agency listed above.

ABUSE THAT MUST BE REPORTED

- Physical injury inflicted by other than accidental means on a child (Penal Code § 11165.6).
- Sexual abuse meaning sexual assault or sexual exploitation of a child (Penal Code § 11165.1).
- Neglect meaning the negligent treatment or maltreatment of a child by a parent or caretaker under circumstances indicating harm or threatened harm to the child’s health or welfare (Penal Code § 11165.2).
- Willful harming or injuring or endangering a child meaning a situation in which any person inflicts, or willfully causes or permits a child to suffer, unjustifiable physical pain or mental suffering, or causes or permits a child to be placed in a situation in which the child or child’s health is endangered (Penal Code § 11165.3).
- Unlawful corporal punishment or injury willfully inflicted upon a child and resulting in a traumatic condition (Penal Code § 11165.4).

WHAT IS NOT CHILD ABUSE?

The law does not consider the following child abuse for reporting purposes:

- Corporal punishment that is not cruel or inhumane or does not result in a traumatic condition
- Injuries caused by two children fighting during a mutual altercation (Penal Code § 11165.4).
- An injury caused by reasonable and necessary force used by a peace officer acting within the course and scope of his or her employment (Penal Code § 11165.6)
- Reasonable and necessary force used by public school officials to quell a disturbance threatening physical injury to person or damage to property (Penal Code § 11165.4)
- Voluntary sexual conduct between minors
- Not receiving medical treatment for religious reasons (Penal Code § 11165.2(b))
- An informed and appropriate medical decision made by a parent or guardian after consultation with a physician who has examined the child (Penal Code § 11165.2(b))

IMMUNITY AND CONFIDENTIALITY OF REPORTER

No mandated reporter shall be civilly or criminally liable for any report required or authorized by law (Penal Code § 11172(a)). The identity of a mandated reporter who makes a report, and the report itself, is confidential and disclosed only among appropriate agencies (Penal Code § 11167(d)(1)).

PENALTY FOR FAILURE TO REPORT ABUSE

A mandated reporter who fails to make a required report is guilty of a misdemeanor punishable by up to six months in jail, a fine of \$1,000, or both. Any mandated reporter who willfully fails to report abuse or neglect, or any administrator or supervisor who impedes or inhibits a report of abuse, where that abuse results in death or great bodily injury, shall be punished by up to one year in jail, a fine of \$5,000, or both.

COPY OF THE LAW AND ACKNOWLEDGEMENT OF RESPONSIBILITY

I have read the above statement and will comply with the applicable reporting requirements.

Employee's Name: _____

Employee's Email Address: _____

Employee Phone: _____

Signature: _____ Date: _____

Enclosed are the following attachments:

Attachment A – Form SS 8572, Suspected Child Abuse Report Form

Note: An original signed version of this Acknowledgement will be maintained in the employee's personnel file.



COVID-19 PREVENTION PLAN EMPLOYEE INFORMATION

The Conejo Valley Unified School District is concerned about preventing the spread of the COVID-19 virus at work and has put in place a COVID-19 Prevention Plan. This plan is posted on the Human Resources page of the district's website. The district is committed towards compliance with all State and County health department requirements and updates its plan as requirements from regulatory agencies are revised. The following information from this plan is being provided to you for your safety and to enable your efforts in controlling the spread of this disease.

Nature of the Disease

There are three main ways that COVID-19 can spread:

1. By breathing in air carrying droplets or aerosol particles that contain the SARS-CoV-2 virus when close to an infected person or in poorly ventilated spaces with infected persons
2. By having droplets and particles that contain the SARS-CoV-2 virus land on the eyes, nose, or mouth – especially through splashes and sprays like a cough or sneeze
3. By touching the eyes, nose, or mouth with hands that have the SARS-CoV-2 virus particles on them

The droplets that contain the SARS-CoV-2 virus are released when someone with COVID-19 sneezes, coughs, or talks. Infectious droplets can land in the mouths or noses of people who are nearby or possibly be inhaled into the lungs.

There are certain circumstances that can increase the risk of infection for COVID-19 such as poorly ventilated space or enclosed, unventilated vehicles. Other factors that are associated with increased COVID-19 risk include prolonged exposure to those infected with COVID-19, close contact with infected persons, and any other activity that leads to exposure to a greater amount of respiratory droplets and particles.

A wide range of symptoms for COVID-19 have been reported. These symptoms include:

Fever or chills

Cough

Muscle or body aches

Loss of appetite

Sore throat

Nasal congestion or runny nose

Severe Fatigue

Headache

Diarrhea

Nausea

Shortness of breath or difficulty breathing

Loss of smell or taste

The estimated incubation period is between 2 and 14 days with a median of 5 days. It is important to note that some people become infected and do not develop any symptoms or feel ill.

In some cases, people who get COVID-19 can develop severe complications, including difficulty breathing, causing a need for hospitalization. These severe complications may lead to death. The risk of severe disease increases steadily as people age. Additionally, those of all ages with underlying medical conditions, including but not limited to heart disease, diabetes or lung disease, are at higher risk to develop severe COVID-19 compared to those without these conditions. Vaccination is recommended for those persons at higher risk for severe illness.

Prevention

Ventilation: The district has complied with recommendations to increase the level of filtration and fresh air intake for its building ventilation systems. As weather/air quality conditions permit and as practical, employees should maximize the fresh air intake by

keeping windows and exterior doors open. When in a vehicle with students and/or other employees, the windows should be kept down and the AC system set to fresh air intake as weather conditions allow.

Face Coverings: Wearing masks is another important preventative action for COVID-19 as a tight fitting mask works to filter out particles and droplets that may carry the virus. The wearing of a face mask is optional unless required by regulation. When selecting a mask, there are many factors to consider. Masks should have two or more layers of breathable fabric, completely cover the nose and mouth, fit snug against the sides of the face without gaps, and have an adjustable nose wire to prevent air from leaking out of the top of the mask. A mask with a higher level of filtration (N95) is available to employees upon request. Information on the proper use of this mask will also be provided. Employees wanting to obtain N95 masks for use at work should submit this request to their supervisor.

Hand Hygiene: Employees should frequently wash their hands with soap and water for at least 20 seconds and when there is no immediate access to a hand washing station, use hand sanitizer. Hand sanitizer is not as effective as washing with soap and water when the hands are visibly soiled. Hands should be washed before and after: eating, use of the restroom, food preparations, and providing personal services to a student.

Other Protective Equipment: Your specific job duties may require you to wear other personal protective equipment such as gloves, a gown and eye protection. Your supervisor will provide you with instructions on the use of this equipment.

Symptoms of COVID-19: Employees with COVID-19 symptoms, regardless of vaccination status or previous infection, must self-isolate (stay home) and test as soon as possible to determine infection status. An employees who has symptoms that are part of a diagnosed non-COVID medical conditions do not need to isolate or test. COVID-19 home test kits are available at your work site for this testing. Employees may also obtain a test through a free local testing clinic or by their health care provider. Employee who test positive must:

- Stay Home for at least 5 days after start of symptoms (Day 0) or after date of first positive test (Day 0) (if no symptoms).
- Isolation can end after Day 5 if symptoms are not present or are resolving and a diagnostic specimen collected on Day 5 or later tests negative.
- If unable to test, choosing not to test, or testing positive on Day 5 (or later), isolation can end after Day 10 if fever-free for 24 hours without the use of fever-reducing medications.
- If fever is present, isolation should be continued until 24 hours after fever resolves.
- If symptoms, other than fever, are not resolving, continue to isolate until symptoms are resolving or until after Day 10. If symptoms are severe, or if you are at high risk of serious disease, or if you have questions concerning care, you should contact your healthcare provider for available treatments.
- Per Cal OSHA regulations, infected employees must wear a well-fitting mask around others for a total of 10 days, especially in indoor settings.
- You may submit a claim for workers' compensation benefits if you believe that your infection was contracted at work.

Exposure to a Person Testing Positive:

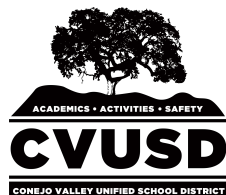
- Test within 3–5 days after last exposure. Persons infected within the prior 30 days do not need to be tested unless symptoms develop.
- Those in close contact with a positive case should wear a well-fitting mask around others for a total of 10 days from the last day of exposure, especially in indoor settings and when near those at higher risk for severe COVID-19 disease.
- Consider getting vaccinated or boosted.
- If symptoms develop, test, and stay home.
- If a test result is positive, follow the isolation instructions above.

My signature below confirms that I have read and understand the above information. Furthermore, I understand that I may contact my supervisor, the Human Resources Department or the Risk Management Department if I have any questions or concerns related to COVID-19 prevention or control in the workplace.

Name (print)

Date

Signature



CONEJO VALLEY UNIFIED SCHOOL DISTRICT
PERSONNEL SERVICES DIVISION
1400 E. Janss Road, Thousand Oaks, California 91362
Telephone (805) 497-9511 • FAX (805) 494-3741

CONVICTION DISCLOSURE STATEMENT

INSTRUCTIONS: All prospective employees **MUST** complete this form even if an applicant does not have a criminal record or any convictions.

Our responsibility to school children and the public, as well as provisions outlined in the State Education Code, Section 45123 and 45124, require every employee to be fingerprinted as a condition of employment. Employees **will not** begin their assignment until fingerprint clearance has been received from the California State Department of Justice and the Federal Bureau of Investigation by Personnel Services. **PLEASE NOTE:** A criminal record does not necessarily exclude you from employment with the Conejo Valley Unified School District; however, falsification of this form or omission of any conviction(s) **will disqualify** you from employment with the Conejo Valley Unified School District.

TITLE OF POSITION APPLIED FOR: _____

Last Name First Name Middle Name Suffix

Former names: _____

BIRTH DATE ____/____/____ **SSN** ____—____—____ **DL#** _____

NOTE:

- ⇒ In the spaces below, give complete details for every time you, as a juvenile or adult have been convicted (fined, imprisoned, placed on probation, given a suspended sentence, or have forfeited bail) in connection with any offense, in civilian or military life.
- ⇒ List all convictions even if they have been expunged or subsequently dismissed. You must answer "YES" to the questions in Part A, if you were convicted, whether by plea of guilty or no contest, jury verdict, or finding of guilt by a court in a trial without a jury. Even if you had an order under Penal Code Section 1203.4 allowing the withdrawal of a plea of guilty and entering a plea of not guilty, or setting aside a verdict of guilty or dismissing the accusations or information, it will still appear on your fingerprint report.
- ⇒ If you use penal code numbers, note that use of incorrect codes will delay processing of your application.
- ⇒ If you are in doubt, list your conviction and explain.
- ⇒ If available, you may attach copies of court documents that identify the specific charge or conviction.
- ⇒ Omit any conviction specified in Labor Code 432.8, which refers to various marijuana related offenses that are more than two years old.
- ⇒ Do not include minor traffic violations such as parking or speeding unless you were convicted for failure to appear for fine or sentencing.
- ⇒ Do not include arrests which resulted in a Court Ordered Diversion Program unless you were convicted for failure to meet the conditions of your program.

PART A — HAVE YOU EVER BEEN CONVICTED?

☐ YES	☐ NO	Have you ever been convicted, fined, imprisoned, placed on probation, or given a suspended sentence by a civilian or military court for any crime? (Do not include traffic violation with a fine of \$250 or less.) If YES, list <u>all</u> such cases below in Part B. You may write on the back if you need additional space.
☐ YES	☐ NO	Do you currently have any criminal charges pending against you?

PART B — CONVICTION DISCLOSURE DETAIL:

<u>DATE OF ARREST</u> (Month-Day-Year)	<u>CITY AND STATE OF ARREST</u>	<u>CHARGE AND DISPOSITION</u> • Length of time served in jail or prison. • Length of probation.	<u>EXPLANATION</u> (Optional)

If necessary, use additional sheets of paper then sign and date the bottom of each additional page.

EMPLOYEE CERTIFICATION OF CONVICTION DISCLOSURES

I certify that this Report of Convictions is true to the best of my knowledge and belief.

Signature

Date



PERSONAL DATA SELF-DISCLOSURE (CONFIDENTIAL)

EMPLOYEE PERSONAL INFORMATION

LEGAL NAME

Last _____ First _____ Middle _____ Suffix _____
Former Name(s) (e.g., Maiden name) _____

BIRTH DATE ____ / ____ / ____ SSN XXX ____ XX ____ DL# _____

DEMOGRAPHIC INFORMATION

GENDER:

☐ Female ☐ Male
☐ Non-Binary

MARITAL STATUS:

☐ Single ☐ Married
☐ Domestic Partner

CITIZENSHIP STATUS:

☐ U.S. Native ☐ Naturalized US Citizen
☐ Alien Resident # _____
☐ Non-Resident Alien _____

SELF-DISCLOSURE OF DISABILITY

Federal and State law and District policy require that new employees be given the opportunity to identify themselves as disabled; disabled veteran; disabled, mentally or physically but not a veteran. This confidential information is used to evaluate compliance with federal and non-discrimination requirements and for statistical purposes only.

Check one only: ☐ No Military Service ☐ Veteran, other than Vietnam era, not disabled
☐ Active Reserve ☐ Veteran, other than Vietnam era, disabled
☐ Inactive Reserve ☐ Vietnam era veteran, not disabled
☐ Disabled, mentally or physically ☐ Vietnam era veteran, disabled

If you have identified yourself as disabled, do you require job accommodation? ☐ Yes ☐ No

If "Yes", please specify the type of job accommodation you require to perform the essential job functions on the "Health Status Questionnaire, Form CP-04"

ETHNICITY / RACE—District policy requires that new employees identify their race/ethnicity using the two questions below:

Are you Hispanic or Latino? (check one): ☐ Yes ☐ No

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

☐ American Indian or Alaskan Native - Origins of North, Central, or South America	☐ Hmong	☐ Tahitian
☐ African American or Black	☐ Hawaiian	☐ Vietnamese
☐ Cambodian	☐ Indian Asian	☐ White - Origins in any original peoples of Europe, N. Africa, or the Middle East
☐ Chinese	☐ Japanese	☐ Other Asian
☐ Filipino	☐ Korean	☐ Other Pacific Islander
☐ Guamanian	☐ Laotian	
	☐ Samoan	

EMPLOYEE CERTIFICATION OF PERSONAL INFORMATION

Signature

Date



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)		Additional Information				
Issuing Authority						
Document Number (if any)						
Expiration Date (if any)						
Document Title 3 (if any)						
Issuing Authority		☐ Check here if you used an alternative procedure authorized by DHS to examine documents.				
Document Number (if any)						
Expiration Date (if any)						
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 Conejo Valley Unified School District			Employer's Business or Organization Address, City or Town, State, ZIP Code 750 Mitchell Road, Newbury Park, CA, 91320			

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		LIST B	LIST C
Documents that Establish Both Identity and Employment Authorization	OR	Documents that Establish Identity	AND 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	
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		For persons under age 18 who are unable to present a document listed above:	
		10. School record or report card	
		11. Clinic, doctor, or hospital record	
			12. Day-care or nursery school record
Acceptable Receipts May be presented in lieu of a document listed above for a temporary period. For receipt validity dates, see the M-274.			
• Receipt for a replacement of a lost, stolen, or damaged List A document. • Form I-94 issued to a lawful permanent resident that contains an I-551 stamp and a photograph of the individual. • Form I-94 with "RE" notation or refugee stamp issued to a refugee.	OR	Receipt for a replacement of a lost, stolen, or damaged List B document.	Receipt for a replacement of a lost, stolen, or damaged List C document.

*Refer to the Employment Authorization Extensions page on [I-9 Central](#) for more information.



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

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

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

Last Name (<i>Family Name</i>) from Section 1 .	First Name (<i>Given Name</i>) 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 (<i>mm/dd/yyyy</i>)	
Last Name (<i>Family Name</i>)	First Name (<i>Given Name</i>)		Middle Initial (<i>if any</i>)
Address (<i>Street Number and Name</i>)	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 (<i>mm/dd/yyyy</i>)	
Last Name (<i>Family Name</i>)	First Name (<i>Given Name</i>)		Middle Initial (<i>if any</i>)
Address (<i>Street Number and Name</i>)	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 (<i>mm/dd/yyyy</i>)	
Last Name (<i>Family Name</i>)	First Name (<i>Given Name</i>)		Middle Initial (<i>if any</i>)
Address (<i>Street Number and Name</i>)	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 (<i>mm/dd/yyyy</i>)	
Last Name (<i>Family Name</i>)	First Name (<i>Given Name</i>)		Middle Initial (<i>if any</i>)
Address (<i>Street Number and Name</i>)	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 (<i>Family Name</i>) from Section 1 .	First Name (<i>Given Name</i>) 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 (<i>if applicable</i>)	New Name (<i>if applicable</i>)		
Date (<i>mm/dd/yyyy</i>)	Last Name (<i>Family Name</i>)	First Name (<i>Given Name</i>)	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) (<i>mm/dd/yyyy</i>)	
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 (<i>mm/dd/yyyy</i>)	
Additional Information (Initial and date each notation.)			☐ Check here if you used an alternative procedure authorized by DHS to examine documents.

Date of Rehire (<i>if applicable</i>)	New Name (<i>if applicable</i>)		
Date (<i>mm/dd/yyyy</i>)	Last Name (<i>Family Name</i>)	First Name (<i>Given Name</i>)	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) (<i>mm/dd/yyyy</i>)	
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 (<i>mm/dd/yyyy</i>)	
Additional Information (Initial and date each notation.)			☐ Check here if you used an alternative procedure authorized by DHS to examine documents.

Date of Rehire (<i>if applicable</i>)	New Name (<i>if applicable</i>)		
Date (<i>mm/dd/yyyy</i>)	Last Name (<i>Family Name</i>)	First Name (<i>Given Name</i>)	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) (<i>mm/dd/yyyy</i>)	
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 (<i>mm/dd/yyyy</i>)	
Additional Information (Initial and date each notation.)			☐ Check here if you used an alternative procedure authorized by DHS to examine documents.



CONEJO VALLEY UNIFIED SCHOOL DISTRICT
HUMAN RESOURCES DEPARTMENT
750 Mitchell Road, Thousand Oaks, California 91320
Telephone (805) 498-4557

DIRECT DEPOSIT-AUTHORIZATION AGREEMENT

REQUEST TYPE: ☐ BEGIN DIRECT DEPOSIT ☐ CHANGE ☐ ADDITIONAL ACCOUNT ☐ CANCEL DEPOSIT

Last Name _____ First Name _____ Middle Initial _____ Suffix _____

XXX - XX -

Social Security No. (Last 4 digits)

Work Location _____

Work Phone # _____

DIRECT DEPOSIT #1	DIRECT DEPOSIT #2 (OPTIONAL)	DIRECT DEPOSIT #3 (OPTIONAL)
BANK ACCOUNT (check one) : ☐ Checking ☐ Savings BANK NAME: _____ ACCOUNT # _____ I wish to deposit (check one): ☐ ALL Net Pay ☐ Specific Dollar Amount \$ _____	BANK ACCOUNT (check one) : ☐ Checking ☐ Savings BANK NAME: _____ ACCOUNT # _____ I wish to deposit (check one): ☐ Specific Dollar Amount \$ _____ ☐ Remainder of Net Pay	BANK ACCOUNT (check one) : ☐ Checking ☐ Savings BANK NAME: _____ ACCOUNT # _____ I wish to deposit (check one): ☐ Specific Dollar Amount \$ _____ ☐ Remainder of Net Pay

YOU MUST ATTACH A VOIDED CHECK(S) OR BANK FORM FOR EACH ACCOUNT REQUESTED.

EMPLOYEE ACKNOWLEDGEMENT OF PAYROLL/LOST CHECK POLICY AND DIRECT DEPOSIT AUTHORIZATION

I hereby authorize the Ventura County Superintendent of Schools Office (VCSSO), and/or their agents, including CVUSD, to initiate electronic deposits and, as necessary, debit corrections to previous deposits, to the above account(s).

I agree to hold harmless and indemnify VCSSO and CVUSD, and its officers and employees from any claim or demand of whatever nature, including those based upon negligence of VCSSO or CVUSD and its officers and employees for failure or delay in making deposits and/or corrections to deposits as herein authorized.

I further understand:

- ◆ Direct deposit is not activated until the month following a successful \$0 test transaction (up to 2 payroll cycles).
- ◆ I hereby authorize the email delivery of my monthly payroll direct deposit remittance advice (paystub) to a designated email address. *For security purposes we recommend using your CVUSD email.*
☐ CVUSD email (for permanent employees only) ☐ Personal Email Address: _____
- ◆ Email delivery of my Remittance Advice may be suspended if 2 consecutive reports are rejected, or if Direct Deposit is suspended.
- ◆ I understand access to my encrypted file will require entering the last 4 digits of my social security number.
- ◆ I must submit a new authorization form if I change my email address, or wish my Remittance Advice sent to a different email address.
- ◆ I must submit a new authorization form if I change my account (name, branch, etc.) or if such changes occur as the result of a merger, buy-out, etc. New forms must be submitted in a timely manner.
- ◆ All changes must be submitted to the CVUSD Payroll Office in a timely manner.
- ◆ Automatic deposit status may be temporarily suspended if wages are garnished, or held for credential reasons.
- ◆ I am responsible for paying any and all fees incurred because of failure on my part to notify CVUSD of any changes in my account information that would result in a return of my deposit.
- ◆ Employees in regular classified positions are paid ONCE a month, at the end of the month when service is rendered. Substitute/Exempt employees who do not hold any regular classified position are on a payment cycle that is one month behind
- ◆ It is the responsibility of the employee to notify the Payroll and/or Human Resources departments of any discrepancies (i.e., overpayments or underpayments) in payment of wages, overtime, shift-differentials, and/or longevity immediately upon discovering an error regardless if its an overpayment or an underpayment of total compensation.
- ◆ Employees shall reimburse the District for any and all "overpayments" regardless if they had or did not have knowledge that an overpayment was occurring.
- ◆ I absolve the Conejo Valley Unified School District of all responsibility in any and all cases where my check may be lost in the mail. I also understand that in all such cases, it is my responsibility to do all checking, tracing, and investigating in the effort to rectify the problem.
- ◆ I understand that if my payroll check is lost, I must submit a statement (V.C.C.S.O. Form #SB1123) to the Payroll Department and that it may take up to 10 days to have the check replaced.

This authorization replaces any previously made by me and is to remain in effect until changed or cancelled by submission of a new Direct Deposit Authorization Agreement.

Employee Signature

Date

Employee's Withholding Certificate

OMB No. 1545-0074

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.

2025**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.)		

TIP: Consider using the estimator at www.irs.gov/W4App to determine the most accurate withholding for the rest of the year if: you are completing this form after the beginning of the year; expect to work only part of the year; or have changes during the year in your marital status, number of jobs for you (and/or your spouse if married filing jointly), dependents, other income (not from jobs), deductions, or credits. Have your most recent pay stub(s) from this year available when using the estimator. At the beginning of next year, use the estimator again to recheck your withholding.

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 the 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

Conejo Valley Unified School District
750 Mitchell Road, Newbury Park, CA 91362

First date of
employment

Employer identification
number (EIN)

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

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 2025 if you meet both of the following conditions: you had no federal income tax liability in 2024 **and** you expect to have no federal income tax liability in 2025. You had no federal income tax liability in 2024 if (1) your total tax on line 24 on your 2024 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 2025 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 17, 2026.

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. Are submitting this form after the beginning of the year;
2. Expect to work only part of the year;
3. Have changes during the year in your marital status, number of jobs for you (and/or your spouse if married filing jointly), or number of dependents, or changes in your deductions or credits;
4. Receive dividends, capital gains, social security, bonuses, or business income, or are subject to the Additional Medicare Tax or Net Investment Income Tax; or
5. Prefer the most accurate withholding for multiple job situations.

TIP: Have your most recent pay stub(s) from this year available when using the estimator to account for federal income tax that has already been withheld this year. At the beginning of next year, use the estimator again to recheck your withholding.

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. Submit a separate Form W-4 for each job.

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 2025 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 2025 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:

{	• \$30,000 if you're married filing jointly or a qualifying surviving spouse	}		2	\$ _____
	• \$22,500 if you're head of household				
	• \$15,000 if you're single or married filing separately				

- 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	\$700	\$850	\$910	\$1,020	\$1,020	\$1,020	\$1,020	\$1,020	\$1,020	\$1,020
\$10,000 - 19,999	0	700	1,700	1,910	2,110	2,220	2,220	2,220	2,220	2,220	2,220	3,220
\$20,000 - 29,999	700	1,700	2,760	3,110	3,310	3,420	3,420	3,420	3,420	3,420	4,420	5,420
\$30,000 - 39,999	850	1,910	3,110	3,460	3,660	3,770	3,770	3,770	3,770	4,770	5,770	6,770
\$40,000 - 49,999	910	2,110	3,310	3,660	3,860	3,970	3,970	3,970	4,970	5,970	6,970	7,970
\$50,000 - 59,999	1,020	2,220	3,420	3,770	3,970	4,080	4,080	5,080	6,080	7,080	8,080	9,080
\$60,000 - 69,999	1,020	2,220	3,420	3,770	3,970	4,080	5,080	6,080	7,080	8,080	9,080	10,080
\$70,000 - 79,999	1,020	2,220	3,420	3,770	3,970	5,080	6,080	7,080	8,080	9,080	10,080	11,080
\$80,000 - 99,999	1,020	2,220	3,420	4,620	5,820	6,930	7,930	8,930	9,930	10,930	11,930	12,930
\$100,000 - 149,999	1,870	4,070	6,270	7,620	8,820	9,930	10,930	11,930	12,930	14,010	15,210	16,410
\$150,000 - 239,999	1,870	4,240	6,640	8,190	9,590	10,890	12,090	13,290	14,490	15,690	16,890	18,090
\$240,000 - 259,999	2,040	4,440	6,840	8,390	9,790	11,100	12,300	13,500	14,700	15,900	17,100	18,300
\$260,000 - 279,999	2,040	4,440	6,840	8,390	9,790	11,100	12,300	13,500	14,700	15,900	17,100	18,300
\$280,000 - 299,999	2,040	4,440	6,840	8,390	9,790	11,100	12,300	13,500	14,700	15,900	17,100	18,300
\$300,000 - 319,999	2,040	4,440	6,840	8,390	9,790	11,100	12,300	13,500	14,700	15,900	17,170	19,170
\$320,000 - 364,999	2,040	4,440	6,840	8,390	9,790	11,100	12,470	14,470	16,470	18,470	20,470	22,470
\$365,000 - 524,999	2,790	6,290	9,790	12,440	14,940	17,350	19,650	21,950	24,250	26,550	28,850	31,150
\$525,000 and over	3,140	6,840	10,540	13,390	16,090	18,700	21,200	23,700	26,200	28,700	31,200	33,700

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	\$200	\$850	\$1,020	\$1,020	\$1,020	\$1,370	\$1,870	\$1,870	\$1,870	\$1,870	\$1,870	\$2,040
\$10,000 - 19,999	850	1,700	1,870	1,870	2,220	3,220	3,720	3,720	3,720	3,720	3,890	4,090
\$20,000 - 29,999	1,020	1,870	2,040	2,390	3,390	4,390	4,890	4,890	4,890	5,060	5,260	5,460
\$30,000 - 39,999	1,020	1,870	2,390	3,390	4,390	5,390	5,890	5,890	6,060	6,260	6,460	6,660
\$40,000 - 59,999	1,220	3,070	4,240	5,240	6,240	7,240	7,880	8,080	8,280	8,480	8,680	8,880
\$60,000 - 79,999	1,870	3,720	4,890	5,890	7,030	8,230	8,930	9,130	9,330	9,530	9,730	9,930
\$80,000 - 99,999	1,870	3,720	5,030	6,230	7,430	8,630	9,330	9,530	9,730	9,930	10,130	10,580
\$100,000 - 124,999	2,040	4,090	5,460	6,660	7,860	9,060	9,760	9,960	10,160	10,950	11,950	12,950
\$125,000 - 149,999	2,040	4,090	5,460	6,660	7,860	9,060	9,950	10,950	11,950	12,950	13,950	14,950
\$150,000 - 174,999	2,040	4,090	5,460	6,660	8,450	10,450	11,950	12,950	13,950	15,080	16,380	17,680
\$175,000 - 199,999	2,040	4,290	6,450	8,450	10,450	12,450	13,950	15,230	16,530	17,830	19,130	20,430
\$200,000 - 249,999	2,720	5,570	7,900	10,200	12,500	14,800	16,600	17,900	19,200	20,500	21,800	23,100
\$250,000 - 399,999	2,970	6,120	8,590	10,890	13,190	15,490	17,290	18,590	19,890	21,190	22,490	23,790
\$400,000 - 449,999	2,970	6,120	8,590	10,890	13,190	15,490	17,290	18,590	19,890	21,190	22,490	23,790
\$450,000 and over	3,140	6,490	9,160	11,660	14,160	16,660	18,660	20,160	21,660	23,160	24,660	26,160

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	\$450	\$850	\$1,000	\$1,020	\$1,020	\$1,020	\$1,020	\$1,870	\$1,870	\$1,870	\$1,890
\$10,000 - 19,999	450	1,450	2,000	2,200	2,220	2,220	2,220	3,180	4,070	4,070	4,090	4,290
\$20,000 - 29,999	850	2,000	2,600	2,800	2,820	2,820	3,780	4,780	5,670	5,690	5,890	6,090
\$30,000 - 39,999	1,000	2,200	2,800	3,000	3,020	3,980	4,980	5,980	6,890	7,090	7,290	7,490
\$40,000 - 59,999	1,020	2,220	2,820	3,830	4,850	5,850	6,850	8,050	9,130	9,330	9,530	9,730
\$60,000 - 79,999	1,020	3,030	4,630	5,830	6,850	8,050	9,250	10,450	11,530	11,730	11,930	12,130
\$80,000 - 99,999	1,870	4,070	5,670	7,060	8,280	9,480	10,680	11,880	12,970	13,170	13,370	13,570
\$100,000 - 124,999	1,950	4,350	6,150	7,550	8,770	9,970	11,170	12,370	13,450	13,650	14,650	15,650
\$125,000 - 149,999	2,040	4,440	6,240	7,640	8,860	10,060	11,260	12,860	14,740	15,740	16,740	17,740
\$150,000 - 174,999	2,040	4,440	6,240	7,640	8,860	10,860	12,860	14,860	16,740	17,740	18,940	20,240
\$175,000 - 199,999	2,040	4,440	6,640	8,840	10,860	12,860	14,860	16,910	19,090	20,390	21,690	22,990
\$200,000 - 249,999	2,720	5,920	8,520	10,960	13,280	15,580	17,880	20,180	22,360	23,660	24,960	26,260
\$250,000 - 449,999	2,970	6,470	9,370	11,870	14,190	16,490	18,790	21,090	23,280	24,580	25,880	27,180
\$450,000 and over	3,140	6,840	9,940	12,640	15,160	17,660	20,160	22,660	25,050	26,550	28,050	29,550

[Clear Form](#)

Employee's Withholding Allowance Certificate

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

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

1. Use Worksheet A for Regular Withholding allowances. Use other worksheets on the following pages as applicable.

1a. Number of Regular Withholding Allowances (**Worksheet A**)

1b. Number of allowances from the Estimated Deductions (**Worksheet B**)

1c. Total Number of Allowances you are claiming

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

OR

Exemption from Withholding

3. I claim exemption from withholding for 2025, and I certify I meet both conditions for exemption.

(Check box here) ☐

OR

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

(Check box here) ☐

Under penalty 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
--	--

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

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

If you do not provide your employer a completed DE 4, your 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 and state income tax last year, and
2. You do not expect to owe any federal and state income tax this 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 and state income tax withheld this year but expect to have a tax liability next year, you are required to give your employer a new DE 4 by December 1.

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

- (i) Your spouse is a member of the armed forces present in California in compliance with military orders;
- (ii) You are present in California solely to be with your spouse; and
- (iii) You maintain your domicile in another state.

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

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

If you need information on your last *California Resident Income Tax Return* (FTB Form 540), visit the [FTB](http://ftb.ca.gov) (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 \(CCR\)](http://govt.westlaw.com/calregs/Search/Index) (govt.westlaw.com/calregs/Search/Index), the FTB or the EDD may 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. 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](http://leginfo.ca.gov/faces/codes.xhtml) (leginfo.ca.gov/faces/codes.xhtml) and section 19176 of the [Revenue and Taxation Code](http://leginfo.ca.gov/faces/codes.xhtml) (leginfo.ca.gov/faces/codes.xhtml).

Worksheets

Instructions — 1 — Allowances*

When determining your withholding allowances, you must consider your personal situation:

- Do you claim allowances for dependents or blindness?
- Will you itemize your deductions?
- Do you have more than one income coming into the household?

Two-Earners or Multiple Incomes: When earnings come 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:

- (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 percent of the costs of maintaining a home for the **entire** year for yourself and your dependent(s) or other qualifying individuals. Cost of maintaining the home includes such items as rent, property insurance, property taxes, mortgage interest, repairs, utilities, and cost of food. It does not include the individual's personal expenses or any amount which represents value of services performed by a member of the household of the taxpayer.

Worksheet A

Regular Withholding Allowances

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

Instructions — 2 — Additional Withholding Allowances (Optional)

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 \$11,080 if married filing joint with two or more allowances, unmarried head of household, or qualifying widow(er) with dependent(s) or \$5,540 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
enter this number on line 1b of the DE 4. Complete Worksheet C, if needed, otherwise stop here . | 8. |
| 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. Then, complete Worksheet C. | 11. |

*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, 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 2025. 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 2025 tax rate schedules below. 8.
9. Enter personal exemptions (line F of Worksheet A x \$149). 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 2025. 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 2025. 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 2025. 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 2025 Only

**Single Persons, Dual Income Married
or Married With Multiple Employers**

IF THE TAXABLE INCOME IS		COMPUTED TAX IS		
OVER	BUT NOT OVER	OF AMOUNT OVER...	PLUS	
\$0	\$10,756	1.100%	\$0	\$0.00
\$10,756	\$25,499	2.200%	\$10,756	\$118.32
\$25,499	\$40,245	4.400%	\$25,499	\$442.67
\$40,245	\$55,866	6.600%	\$40,245	\$1,091.49
\$55,866	\$70,606	8.800%	\$55,866	\$2,122.48
\$70,606	\$360,659	10.230%	\$70,606	\$3,419.60
\$360,659	\$432,787	11.330%	\$360,659	\$33,092.02
\$432,787	\$721,314	12.430%	\$432,787	\$41,264.12
\$721,314	\$1,000,000	13.300%	\$721,314	\$77,128.03
\$1,000,000	and over	14.630%	\$1,000,000	\$114,834.25

Married Persons

IF THE TAXABLE INCOME IS		COMPUTED TAX IS		
OVER	BUT NOT OVER	OF AMOUNT OVER...	PLUS	
\$0	\$21,512	1.100%	\$0	\$0.00
\$21,512	\$50,998	2.200%	\$21,512	\$236.63
\$50,998	\$80,490	4.400%	\$50,998	\$885.32
\$80,490	\$111,732	6.600%	\$80,490	\$2,182.97
\$111,732	\$141,212	8.800%	\$111,732	\$4,244.94
\$141,212	\$721,318	10.230%	\$141,212	\$6,839.18
\$721,318	\$865,574	11.330%	\$721,318	\$66,184.02
\$865,574	\$1,000,000	12.430%	\$865,574	\$82,528.22
\$1,000,000	\$1,442,628	13.530%	\$1,000,000	\$99,237.37
\$1,442,628	and over	14.630%	\$1,442,628	\$159,124.94

Unmarried/Head of Household

IF THE TAXABLE INCOME IS		COMPUTED TAX IS		
OVER	BUT NOT OVER	OF AMOUNT OVER...	PLUS	
\$0	\$21,527	1.100%	\$0	\$0.00
\$21,527	\$51,000	2.200%	\$21,527	\$236.80
\$51,000	\$65,744	4.400%	\$51,000	\$885.21
\$65,744	\$81,364	6.600%	\$65,744	\$1,533.95
\$81,364	\$96,107	8.800%	\$81,364	\$2,564.87
\$96,107	\$490,493	10.230%	\$96,107	\$3,862.25
\$490,493	\$588,593	11.330%	\$490,493	\$44,207.94
\$588,593	\$980,987	12.430%	\$588,593	\$55,322.67
\$980,987	\$1,000,000	13.300%	\$980,987	\$104,097.24
\$1,000,000	and over	14.630%	\$1,000,000	\$106,669.70

If you need information on your last California Resident Income Tax Return, FTB Form 540, visit [FTB](https://ftb.ca.gov) (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. More information is in the instructions that came with your last California resident income tax return.

Retirement System Status Questionnaire

Last Name _____ First Name _____ Middle _____

Social Security Number _____ Birth Date _____

Are you currently or have you ever been a member of:

- ☐ Public Employees' Retirement System (**CalPERS**)
(If you have reciprocal rights with another agency, please complete the Member Reciprocal Self-Certification Form.)
- ☐ State Teachers' Retirement System (**CalSTRS**)
- ☐ I have never been a member of **CalPERS** or **CalSTRS**

Name of Employer(s) if current or previous member: _____

EMPLOYER USE ONLY

Retirement record begin date: _____

Retirement Plan: ☐ STRS ☐ PERS

Member Status: ☐ 1- Member ☐ 2- Non-Member or Retiree

Plan Option: ☐ O—Pre 2013 (membership prior to 2013) ☐ N—New (membership post 2013)

Member Type: ☐ E —Elected Member ☐ N —Non Member ☐ Q -Qualified Member
☐ R —Retiree ☐ Y — Existing member

Crossover? ☐ Yes ☐ No

Member Status Date: _____

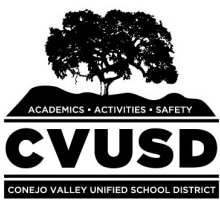
PERS Member ID: _____ (log into MyCalPERS for this information)

STRS Assignment Code: _____

STRS Member ID: _____ (log into STRS SEW for this information, also known as STRS client ID)

Information has been verified to Escape:

District: _____ Contact: _____ Date: _____



CONEJO VALLEY UNIFIED SCHOOL DISTRICT
HUMAN RESOURCES DEPARTMENT
750 Mitchell Road Newbury Park, CA 91320
Telephone (805) 498-4557

RETIREMENT SYSTEM STATUS QUESTIONNAIRE

1. EMPLOYEE PERSONAL INFORMATION:

Last Name _____ First Name _____ Middle Name _____ Suffix _____

Former Name(s) (e.g. Maiden name) _____

Social Security No.

Date of Birth (MM/DD/YYYY)

Position Title

2. PREVIOUS / CURRENT RETIREMENT SYSTEM HISTORY

PART A. Are you currently a member or have you ever been a member of :

⇒ California State Teachers' Retirement System (CalSTRS) ☐ No ☐ Yes-complete Part B

⇒ California Public Employees' Retirement System (CalPERS) ☐ No ☐ Yes-complete Part B

Examples: K-12 school district; state university; state agency; fire/police department, etc.

PART B. Identify Retirement System: (Check all applicable boxes)

PUBLIC EMPLOYER NAME	ASSIGNMENT TERM		CURRENTLY EMPLOYED?	SYSTEM MEMBER		RETIRED, DRAWING PENSION	CONTRIBUTION STATUS	
	Full-Time	Part-Time		STRS	PERS		Withdrawn	Remain on Account ¹
	☐	☐	☐	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐	☐	☐	☐

¹ Not currently working, but contribution funds are on deposit with STRS or PERS

*If necessary, use additional sheets of paper: sign and date the bottom of each additional page.

***IMPORTANT NOTICE ***

- ♦ **YOU are responsible for knowing and not exceeding your retirement system's post-retirement service limit.**
- ♦ **STRS** post-retirement earnings are limited to the fiscal year dollar amount established by STRS. If you are retired from STRS you may only work in a District position that is designated **CERTIFICATED**. In accord with STRS rules and regulations, retirees are not permitted to be employed in assignments designated by the District as **CLASSIFIED** for purposes of retirement system enrollment.
- ♦ **PERS** post-retirement work is limited to a Fiscal Year (July 1– June 30) maximum 960 hours of work. If you are retired from PERS you may work in an unclassified/exempt, temporary certificated and classified substitute assignment. **In accord with PERS rules and regulations you may not hold assignments in regular permanent classified service.**
- ♦ If you are a member of one retirement system and subsequently qualify for membership in the other system, you will receive documents from the Payroll department notifying you of your right to change the retirement system enrollment and respective timelines.
- ♦ If you are collecting retirement benefits and seeking employment in a position that may ultimately jeopardize your retirement benefits, it is your responsibility to contact a representative from STRS/PERS to ensure your employment in the above specified position will not impact your retirement status.

EMPLOYEE ACKNOWLEDGMENT AND CERTIFICATION

I certify that I have received retirement system information and understand that if I qualify to make a retirement system election, I must submit all required forms to the CVUSD Fiscal department within 60 days of having received them.

Signature

Date

PERSONNEL / PAYROLL DEPARTMENT USE ONLY

POSITION ASSIGNMENT DESIGNATION: ☐ Certificated ☐ Classified ☐ Non-classified / Exempt

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

Employee Name: _____

Employee ID#: _____

Employer Name: _____

Employer ID#: _____

Your earnings from this job are not covered under Social Security (i.e., you will not pay Social Security taxes). This means that you will not earn credits for Social Security retirement or disability benefits in this job. If you retire or become disabled, and you are eligible for a Social Security benefit based on other work, your earnings from this job will not be used to compute your Social Security benefit. In addition, we will not consider these non-covered earnings for the future potential calculation of survivor benefits based on your earnings. Your earnings from this job are subject to Medicare taxes and will count for purposes of the Medicare program. For information on how you may qualify for Social Security benefits, visit www.ssa.gov.

For More Information

Social Security publications and additional information are available at www.ssa.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 and understand that my earnings from this job are not covered under Social Security and will not be used to determine eligibility to or the amount of 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

The Social Security Protection Act of 2004, Pub. L. No. 108-203, Section 419 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. Form SSA-1945, **Statement Concerning Your Employment in a Job Not Covered by Social Security**, is the document that employers must use to meet the requirements of the law.

While the earlier version of the SSA-1945 discussed the effect of the Windfall Elimination Provision and/or Government Pension Offset on an employee's potential future benefits, the Social Security Fairness Act (SSFA) of 2023 enacted on January 5, 2025, eliminated the reduction of Social Security benefits under the Windfall Elimination Provision and/or Government Pension Offset for individuals entitled to certain pensions from work not covered by Social Security, starting January 2024. However, this did not remove the requirement for State and local government employers to provide a statement to employees hired January 1, 2005, or later in jobs not covered under Social Security. This version of SSA-1945 explains to an employee that non-covered earnings will not be used to determine eligibility to or calculate the amount of potential future benefits.

Employers must:

- Get the employee's signature on the form
- Give the signed statement and information page to the employee prior to the start of employment
- 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.

A fillable, downloadable version of the SSA-1945 is available online at the Social Security website, www.ssa.gov/online/ssa-1945.pdf.



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

Employer Account Management Division

Dear Member,

The California Public Employees' Retirement System (CalPERS) requires all members hired after January 1, 2013 complete the ***Reciprocal Self-Certification Form (PERS-EAMD-801)*** to provide essential information that will be used by your employer to enroll you in CalPERS membership.

This form obtains information regarding your membership in other qualifying public retirement systems and *must be returned to your employer within 10 business days of receipt*. Use the instructions provided on the back of the form and reference the List of Qualifying Public Retirement Systems for assistance. Information regarding your membership in a defined benefit plan for any of the listed qualifying public retirement system must be provided. **However, information related to CalPERS membership should not be included when completing this form, as this data is already stored in the CalPERS system.**

It is your responsibility to ensure the accuracy and completeness of the information you provide. Inaccurate information may result in adjustments to your account which could lead to adverse impacts such as incurring financial obligations that you and your employer will be responsible to fulfill.

For more information regarding the ***Reciprocal Self-Certification Form***, please visit our website at www.calpers.ca.gov.

Please note: The completion of the ***Reciprocal Self-Certification Form*** does not establish [reciprocity](#), nor is it a request to establish reciprocity. To request that reciprocity be established, download the **When You Change Retirement Systems (PUB 16)** publication to obtain the **Confirmation of Intent to Establish Reciprocity When Changing Retirement Systems (PERS-CASD-255)** form. This publication is available at www.calpers.ca.gov.

Sincerely,

Membership Services

Enclosures: List of Qualifying Public Retirement Systems in California, ***Reciprocal Self-Certification Form***, and Directions for Completing Reciprocal Self-Certification Form

List of Qualifying Public Retirement Systems in California

Name of Public Retirement System	Qualifications:
Alameda County Employees' Retirement Association [^]	
City and County of San Francisco Employees' Retirement System*	
City of Concord Retirement System*	
City of Costa Mesa Public Retirement System*	Safety only
City of Fresno Retirement System	
City of Pasadena Fire and Police Retirement System	Fire and police only
City of San Clemente*	Non-safety (miscellaneous) only
Contra Costa County Employees' Retirement Association [^]	
Contra Costa Water District	
East Bay Municipal Utility District	
East Bay Regional Park District	Safety only
Fresno County Employees' Retirement Association [^]	
Imperial County Employees' Retirement Association [^]	
Judges Retirement System II	
Kern County Employees' Retirement System [^]	
Legislators' Retirement System	
Los Angeles City Employees' Retirement System	Non-safety (miscellaneous) only; L.A. Fire and Police Pension System and L.A. Water and Power Employees' Retirement System not eligible
Los Angeles County Employees' Retirement Association [^]	
Los Angeles County Metropolitan Transportation Authority	Non-contract Employees' Retirement Income Plan, formerly Southern California Rapid Transit District
Marin County Employees' Retirement Association [^]	
Mendocino County Employees' Retirement Association [^]	
Merced County Employees' Retirement Association [^]	
Oakland Municipal Employees' Retirement System (City of Oakland)	Non-safety (miscellaneous) only
Orange County Employees' Retirement System [^]	
Sacramento City Employees' Retirement System*	
Sacramento County Employees' Retirement System [^]	Defined benefit plan only; cash balance plans not eligible
San Bernardino County Retirement Association [^]	
San Diego City Employees' Retirement System	Defined benefit plan only; cash balance plans not eligible
San Diego County Employees' Retirement Association [^]	
San Joaquin County Employees' Retirement Association [^]	
San Jose Federated City Employees' Retirement System	
San Luis Obispo County Pension Trust	
San Mateo County Employees' Retirement Association [^]	
Santa Barbara County Employees' Retirement System [^]	
Sonoma County Employees' Retirement Association [^]	
Stanislaus County Employees' Retirement Association [^]	
State Teachers' Retirement System	Defined benefit plan only; cash balance plans not eligible
Tulare County Employees' Retirement Association [^]	
University of California Retirement Program	Defined benefit plan only; cash balance plans not eligible
Ventura County Employees' Retirement Association [^]	
*=Also CalPERS-covered agency	[^] =1937 Act Counties



NOTICE OF EXCLUSION FROM CalPERS MEMBERSHIP

1. SOCIAL SECURITY NUMBER	Your employer has contracted with the California Public Employees' Retirement System (CalPERS) to provide an employee benefit package which includes service retirement, death, and disability benefits.		
2. CURRENT NAME (LAST)	(FIRST)	(MIDDLE)	
3. NAME OF PUBLIC AGENCY	4. DEPARTMENT OR SCHOOL DISTRICT Conejo Valley Unified School District	5. JOB OR POSITION TITLE	
6. TERM OF APPOINTMENT ☐ PERMANENT ☐ TEMPORARY	7. IF TEMPORARY, ENTER NEAREST NUMBER OF WHOLE MONTHS THE APPOINTMENT IS EXPECTED TO LAST. MONTHS	8. APPOINTMENT DATE MM DD YYYY	
9. TIME BASE ☐ FULL-TIME ☐ INDETERMINATE ☐ PART-TIME IF PART TIME, ENTER THE FRACTION OF FULL TIME:			

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

- ☐ 1. Your full-time seasonal or limited term appointment is limited to 6 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) this fiscal year.
- ☐ 4. Your position is excluded by law or by contract agreement which excludes:
_____ Enter contract exclusion (for Public Agencies only).
- ☐ 5. You are an independent contractor.
- ☐ 6. You are employed to render professional legal service to a city.
Exceptions: Persons holding the office of city attorney, deputy city attorney, or assistant city attorney.
- ☐ 7. You are employed as a student aide by a school district in a position established for students only and you are attending school in the same district (for County Schools only).

NOTE: If you are a member of CalPERS by previous employment (either you have funds on deposit or service credit), exclusions 1, 2, and 3 do not apply to you and you should be a member in your present position. Be sure to notify your employer to complete a (PERS-1) Member Action Request Form or appoint via ACES to report your employment to CalPERS.

If you believe that your employment does qualify you for CalPERS membership, ask your employer for an explanation. If you still have doubts, you may appeal directly to CalPERS by sending a letter to the Actuarial & Employer Services Branch, Membership Analysis & Design Unit, P.O. Box 942709, Sacramento, CA 94229-2709, stating the reasons why you feel you should be a member.

SIGNATURE OF CERTIFYING OFFICER	TITLE	DATE
SIGNATURE OF EMPLOYEE		DATE

NOTE: Benefits provided by CalPERS are described in the "CalPERS Benefits" information booklet available from your employer.

PERS-AESD-139 (3/08)



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

Reciprocal Self-Certification Form

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

Section 1. Member Information	
Member Name:	(Last) (First) (Middle)
Date of Birth:	CalPERS ID:
Membership Status in Qualifying Public Retirement Systems: ☐ I have not been a member of a qualifying public retirement system in California. (skip to section 3) ☐ I have membership in a defined benefit plan under a qualifying public retirement system in California other than CalPERS. (complete section 2 with membership information for each qualifying public retirement system)	

Section 2. Qualifying Reciprocal Membership Information			
Name of Most Recent Public Retirement System:	Membership Date: / /	Separation Date*: / /	☐ Retired* or ☐ Refunded* Date: / /
Name of Prior Public Retirement System:	Membership Date: / /	Separation Date*: / /	☐ Retired* or ☐ Refunded* Date: / /
Name of Prior Public Retirement System:	Membership Date: / /	Separation Date*: / /	☐ Retired* or ☐ Refunded* Date: / /

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

Section 3. Sign and Certify
I understand that by accepting employment in a qualified public retirement system, I am subject to the applicable laws and regulations of that system. I also understand that completing this form is not a request to establish reciprocity.
I hereby certify that the foregoing information has been verified with the qualifying public retirement system as true and correct and any information found to be incorrect may require corrections to my CalPERS account including, but not limited to, my retirement enrollment level and adjustments to my member contributions. CalPERS may make any necessary corrections to my account to ensure I am properly enrolled and eligible to receive the correct retirement benefits.
Member Signature: _____ Date: _____

Section 4. To Be Completed by Employer Only	
Name of CalPERS Agency: Conejo Valley Unified School District (618)	
CalPERS Business Partner ID:	Member's Enrollment Eligibility Date:
Designee of Employer: (print name)	Designees' Title:
Designee Signature: _____	Date: _____
The employer must retain this form in the member's file for auditing purposes.	
For more direction regarding how to process the Reciprocal Self-Certification Form, please refer to our employer reference guides.	

Instructions for Completing the Reciprocal Self-Certification Form

Section 1. Member Information	• Complete the required fields with your name, date of birth, and CalPERS ID. • Check one of the appropriate boxes to indicate if you have had membership in a defined benefit plan in one of the qualifying public retirement systems named on the enclosed list. – If you have not been a member of any of the qualifying public retirement systems, mark the first box and skip to section 3. – If you have membership in a defined benefit plan of any of the qualifying public retirement systems on the enclosed list, mark the second box and continue to section 2. – This form is to obtain information regarding your membership in <u>other</u> qualifying public retirement systems; do not include CalPERS membership on this form.
Section 2. Qualifying Reciprocal Membership Information	• In the first column, titled “Name of Public Retirement System,” list the name of any qualifying public retirement systems you are a member of a defined benefit plan. – If you are a member of multiple qualifying public retirement systems, please provide the name of each system beginning with the most recent in descending order. – Please reference the enclosed List of Qualifying Public Retirement Systems in California. Only systems named on this list should be provided on the Reciprocal Self-Certification Form. • In the second column, titled “Membership Date,” list your membership date in the qualifying public retirement system. – You must provide a full date, including month, date, and year, which corresponds to each qualifying public retirement system listed. – If you are unsure of your membership date, please contact the qualifying public retirement system to confirm information prior to completing the form. • In the third column, titled “Separation Date,” list your separation date from the qualifying public retirement system. – This section may not be applicable for all qualifying public retirement systems. If you have not separated from the qualifying public retirement system, leave this field blank. – If you have separated from the qualifying public retirement system, you must provide a full date including month, date, and year. – If you are unsure of your separation date, please contact the qualifying public retirement system to confirm information prior to completing the form. • In the fourth column, titled “Retired or Refunded,” indicate if you have retired or refunded from the qualifying public retirement system. – This section may not be applicable for all qualifying public retirement systems. If you have not retired or refunded from the qualifying public retirement system, leave this field blank. – If you have retired or refunded from the qualifying public retirement system, mark the appropriate box and provide a full date including month, date, and year. – Retired: You have separated from the qualifying public retirement system and receive a monthly retirement allowance. – Refunded: You have terminated your membership in the qualifying public retirement system by withdrawing your contributions.
Section 3. Sign and Certify	• Please read the statement. Then, sign your name and date the document before returning it to your personnel office.

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 for administration of Board duties under the Retirement Law, the Social Security Act, and the Public Employees' Medical and Hospital Care Act, as the case may be. Submission of the requested information is mandatory. Failure to comply 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 on a mandatory and 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.

Social Security numbers are used for the following purposes:

1. Enrollee identification
2. Payroll deduction/state contributions
3. Billing of contracting agencies for employee/ employer contributions
4. Reports to CalPERS and other state agencies
5. Coordination of benefits among carriers
6. 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 the System. For questions about this notice, our Privacy Policy, or your rights, please write to the CalPERS Privacy Officer at 400 Q Street, Sacramento, CA 95811 or call us at **888 CalPERS** (or 888-225-7377).



Accumulation Program for Part-time and Limited-service Employees
Acknowledgement and Designation of Beneficiary Form

Employer: Conejo Valley Unified School District ☐ New Enrollment ☐ Address Change ☐ Beneficiary Change

☐ Name Change – Please insert former name here _____ and fill in new name below. You must provide documentation of proof of name change (ie. Copy of Social Security Card, etc.).

Participant Information (please print legibly)

Name: _____ Social Security #: _____ Date of Birth: _____ Male/Female _____
(Last, First)

Address: _____
(Street / PO Box) (Apt. #) (City, State Zip)

Daytime Phone: _____ Evening Phone: _____ Email: _____

Beneficiary Designations If you need more space than provided below, please attach an additional page.

Check one: ☐ I am married and designate the following person(s) to receive death benefits from the Plan.		
☐ I am single and designate the following person(s) to receive death benefits from the Plan.		
Primary Beneficiary Name: _____	Social Security #: _____	Date of Birth: _____
Address: _____	Relationship: _____	Percent: _____
Contingent Beneficiary Name: _____	Social Security #: _____	Date of Birth: _____
Address: _____	Relationship: _____	Percent: _____
SPOUSAL CONSENT		
I consent to this designation that eliminates all or part of the benefits otherwise payable to me from the plan if my spouse dies.		
Spouse Consent Signature _____	Date _____	Notary Public or Employer _____

A \$0.75 monthly fee will be applied to inactive participant account balances. Inactive participants are those participants who have not made a contribution to the plan for one year, are no longer employed with this Employer, and who could, at any time, request a distribution of their account balance. **Effective April 1, 2015, the administrative fee will increase nominally to \$1.00 per month for these inactive participants.**

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

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 2005, the maximum monthly reduction in your Social Security benefit as a result of this provision is \$313.50. 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. Copies of the SSA-1945 are available online at the Social Security website, www.socialsecurity.gov/form1945. Paper copies can be requested by email at oplmsoswm.rqct.orders@ssa.gov or by fax at 410-965-2037. Form SSA-1945(12-2004)

Employee Signature

Print Name

Date

Submit completed form to:
MidAmerica Administrative Solutions
402 South Kentucky Avenue, Suite 500, Lakeland, FL 33801
Fax: (863) 686-9727