

Substitute Teacher Paperwork

The following documents **are required** to work.

- Current Driver's License or State ID (cannot be a copy or LA Wallet, must be the actual card)
- Social Security Card *Application must be completed with the name that matches your social security card
- Birth Certificate
- Proof of your highest level of education
- Voided check or letter f direct deposit from your bank

Note: **Please print out one sided only.** The application must be completed, signed and dated for the date of your appointment. Failure to have all documents will cause your appointment to be rescheduled. Copies of your documents can be made at the time of your appointment. If you have any questions filling out the application, you can call Morgan for help.

- ❖ You must be fingerprinted for a background check at the School Board office. The cost is \$54.50. To be fingerprinted please follow the directions below in order as written.
 - Call Morgan Futch for an appointment.
 - Pre-register for your background check. Read page 2 for steps on how to register for your background check. This is a required step and must be done at least one day before your appointment.
 - Bring all paperwork, required documents and a debt or credit to pay for your background check.
- ❖ You must call the phone number below to make an appointment, cancel or reschedule. If I do not answer, leave your name and number so I can return your call. If you do not leave your name and number, I have no way of knowing you have called. I usually return calls right away unless I am out of the office.

You will come to 1600 N. 7th St. West Monroe, La for your appointment.

Morgan Futch
Phone: 318-432-5230
Email: Morgan.Futch@opsb.net

SUBSTITUTE TEACHER BACKGROUND CHECK INFORMATION

Fingerprint Payment Method: **it is best to do this on a computer or laptop**

Go to:

Opsb.net

Jobs

Substitute Teacher

Fingerprint information

PLEASE READ ALL 6 STEPS BEFORE YOU GO TO STEP 1.

You must have an appointment before you can register for a background check

Step 1: Click the [Identigo Link Here](#).

Step 2: Once on the website, fill out all information.

Step 3: When you get to the part that asks you to pick the location, type in SP-WESTMONROE (just like it is typed here, all caps no spaces).

Step 4: After you type in SP-WESTMONROE, click on the **magnifying glass/search**. **DO NOT CLICK WHERE IT SAYS USE MY LOCATION**. When our location, 1600 N. 7th St, pops up hit the next button that is beside our location information. **DO NOT REGISTER AT THE ST. JOHN LOCATION**. WE DO THE BACKGROUND CHECK HERE IN THE OFFICE.

Step 5: When it asks you to set an appointment date and time, please put in the appointment time that Morgan Futch gave you. If your appointment time is not shown pick the one closest to yours. (Example: If your appointment time is 9:00 a.m., but the only time available is 12:00, choose 12:00 but still show up at 9:00 am.)

Step 6: Bring in paperwork, all identification, and debit card or credit card to pay for your background check to Morgan at the time of your appointment.

Payment is made here in the office when you do your background check. We only take debit or credit cards.

For any other questions, please call Morgan Futch at 318-432-5230.

****If you have ever been arrested for a felony you will not be permitted to work for Ouachita Parish School System. If you had a felony and it was dropped or dismissed, please bring the papers with you at the time of your appointment for proof.**

Fingerprint Privacy Act Statement

This privacy act statement is located on the back of the FD-258 fingerprint card.

Authority: The FBI's acquisition, preservation, and exchange of fingerprints and associated information is generally authorized under 28 U.S.C. 534. Depending on the nature of your application, supplemental authorities include Federal statutes, State statutes pursuant to Pub. L. 92-544, Presidential Executive Orders, and federal regulations. Providing your fingerprints and associated information is voluntary; however, failure to do so may affect completion or approval of your application.

Principal Purpose: Certain determinations, such as employment, licensing, and security clearances may be predicated on fingerprint-based background checks. Your fingerprints and associated information/biometrics may be provided to the employing, investigating, or otherwise responsible agency, and/or the FBI for the purpose of comparing your fingerprints to other fingerprints in the FBI's Next Generation Identification (NGI) system or its successor systems (including civil, criminal, and latent fingerprint repositories) or other available records of the employing, investigating, or otherwise responsible agency. The FBI may retain your fingerprints and associated information/biometrics in NGI after the completion of this application and, while retained, your fingerprints may continue to be compared against other fingerprints submitted to or retained by NGI.

Routine Uses: During the processing of this application and for as long thereafter as your fingerprints and associated information/biometrics are retained in NGI, your information may be disclosed pursuant to your consent, and may be disclosed without your consent as permitted by the Privacy Act of 1974 and all applicable Routine Uses as may be published at any time in the Federal Register, including the Routine Uses for the NGI system and the FBI's Blanket Routine Uses. Routine uses include, but are not limited to, disclosures to: employing, governmental or authorized non-governmental agencies responsible for employment, contracting, licensing, security clearances, and other suitability determinations; local, state, tribal, or federal law enforcement agencies; criminal justice agencies; and agencies responsible for national security or public safety.

As of 03/30/2018

Acknowledgment and Consent

"By signing below, I acknowledge that I have received, read, and understood the Fingerprint Privacy Act Statement. I consent to the collection and processing of my fingerprints for the purposes outlined in this notice."

Signature

Date

Todd Guice
Superintendent

Jason Thompson
Personnel Director

OUACHITA PARISH SCHOOL SYSTEM
1600 NORTH 7TH ST., WEST MONROE, LA 71291
PH: 318-432-5000 Fax: 318-432-5222
SUBSTITUTE TEACHING APPLICATION

Social Security #: _____ Date: _____

Name (as shown on social): _____
Last First M.I. Maiden

Address: _____
Street City State Zip Code

Home Phone #: _____ Cell Phone #: _____

Date of Birth: _____ Employment Status Circle One
*Are you a member of TRSL Yes or No
Teachers' Retirement System of LA Yes or NO

Education: Bachelor _____ Master's _____ Master's +3 _____ Sp.Ed, S. _____ Ph.D. or Ed. D. _____

College/ University Attended _____ # Years Attended _____ Graduation Date _____

Major: _____ Minor: _____

Preferred Schools: _____

Comments: _____

Signature of Applicant

Office Use Only

Certified
Degreed
Non-Degreed

Supervisor Signature

Todd Guice – Superintendent
1600 N. 7th St West Monroe,
La 71291
318-432-5000



Jason Thompson – Chief of Staff
1600 N. 7th St
West Monroe, La 71291
318-432-5206

ARE YOU ARE RETIREE RETURN TO WORK? YES OR NO

HAVE YOU EVER BEEN A SUB FOR OPSB? YES OR NO

HAVE YOU EVER BEEN IN A STATE RETIREMENT SYSTEM?

IF YES, CIRCLE WHICH ONE: TRSL LSERS LASERS ORP

SOCIAL SECURITY NUMBER: _____

LAST NAME: _____

FIRST NAME: _____

DATE OF BIRTH: _____

MAILING ADDRESS: _____

CITY/STATE/ZIP CODE: _____

MALE/FEMALE: _____ RACE: _____

HOME PHONE: _____ CELL: _____

EMAIL ADDRESS: _____

****PLEASE BRING A VOIDED CHECK OR LETTER OF DIRECT DEPOSIT FROM YOUR BANKING INSTITUTE. IF YOU DO NOT BRING ONE OF THESE WITH YOU, YOUR PAY CHECK WILL BE MAILED TO YOU.**

DO NOT FILL OUT BOX BELOW, FOR OFFICE USE ONLY.

Federal Taxes _____		State Taxes _____	
Sub Teacher	\$65	\$75	\$80
Sub Bus Driver	Sub Bus Aide	Sub Clerical	Sub Para
Sub Cafeteria	Sub Custodial	Sub Nurse	

If you are a Long-Term Substitute Teacher please tell us what school and class you will be in.

Todd Guice – Superintendent
1600 N. 7th St
West Monroe, La 71291
318-432-5000



Jason Thompson – Chief of Staff
1600 N. 7th St
West Monroe, La 71291
318-432-5206

AUTHORIZATION FOR ELECTRONIC DEPOSIT

***REQUIRED FOR ALL NEW EMPLOYEES**

I, _____ hereby authorize Ouachita Parish School Board to “Electronically Deposit” my funds on a date specified by OPSB to the bank of my choice. It is understood that this banking procedure is mandatory by Ouachita Parish School Board and is limited to one bank per employee. It is also understood that it is my sole responsibility to notify OPSB of my bank account information as well as any changes made to my bank account in the event of an error in the credit entry, the correction of which requires that a revising (data) entry is made, I hereby authorize the Depository Institution to initiate such a debit entry in the amount of the error of my account.

EMPLOYEE SIGNATURE: _____ DATE: _____

SOCIAL SECURITY NUMBER OR EMPLOYEE ID: _____

ATTACH VOIDED CHECK OR DIRECT DEPOSIT LETTER FROM BANK TO VERIFY BANK INFORMATION AND COMPLETE THE FOLLOW:

BANK NAME: _____

BANK ROUTING NUMBER: _____

ACCOUNT NUMBER: _____

☐ SAVINGS

☐ CHECKING

EMPLOYEE MUST NOTIFY PAYROLL AT LEAST 7 DAYS PRIOR TO PAYDAY OF ANY CHANGE IN DIRECT DEPOSIT STATUS

Employee's Withholding Certificate

Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay.

Give Form W-4 to your employer.

Your withholding is subject to review by the IRS.

OMB No. 1545-0074

2026

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.)		
Caution: To claim certain credits or deductions on your tax return, you (and/or your spouse if married filing jointly) are required to have a social security number valid for employment. See page 2 for more information.			

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 Step 2(b) if pay at the lower paying job is more than half of the pay at the higher paying job. Otherwise, Step 2(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):			
	(a) Multiply the number of qualifying children under age 17 by \$2,200	3(a) \$		
	(b) Multiply the number of other dependents by \$500	3(b) \$		
	Add the amounts from Steps 3(a) and 3(b), plus the amount for other credits. Enter the total here		3	\$
Step 4: 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. Use the Deductions Worksheet on page 4 to determine the amount of deductions you may claim, which will reduce your withholding. (If you skip this line, your withholding will be based on the standard deduction.) Enter the result here		4(b)	\$
	(c) Extra withholding. Enter any additional tax you want withheld each pay period		4(c)	\$

Exempt from withholding	I claim exemption from withholding for 2026, and I certify that I meet both of the conditions for exemption for 2026. See <i>Exemption from withholding</i> on page 2. I understand I will need to submit a new Form W-4 for 2027 ☐
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Step 5: Sign Here	Under penalties of perjury, I declare that this certificate, to the best of my knowledge and belief, is true, correct, and complete.		
	Employee's signature (This form is not valid unless you sign it.)		Date

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



Employee's Withholding Certificate (L-4)

This form must be filed with your employer.

For Questions:

Phone: (855) 307-3893

Send an email by visiting

<https://revenue.louisiana.gov/contact-us/>

Purpose: Complete Form L-4 so that your employer can withhold the correct amount of state income tax from your salary.

Instructions: Employees who are subject to state withholding must provide their expected tax return filing status in Block A.

- Employees must file a new certificate within 10 days if the number of their deductions decreases, except if the change is the result of the death of a spouse.
- Employees may file a new certificate any time the number of their deductions increases.
- Line 7 should be used to increase or decrease the tax withheld for each pay period. Decreases should be indicated as a negative amount.

Penalties will be imposed for willfully supplying false information or willfully failing to supply information that would reduce the withholding amount.

This form must be filed with your employer. If an employee fails to complete this withholding certificate, the employer must withhold Louisiana income tax from the employee's wages without any standard deduction.

Note to Employer: Keep this certificate with your records.

Block A

- Enter "0" to claim no standard deduction and check the appropriate box under number 3 below. You may enter "0" if you are married, and have a working spouse or more than one job to avoid having too little tax withheld.
- Enter "1" to claim a standard deduction if your filing status is single or married filing separate and check the appropriate box under number 3 below if you did not claim this deduction in connection with other employment or if your spouse has not claimed a deduction.
- Enter "2" to claim a standard deduction if your filing status is married filing jointly, head of household, or qualifying surviving spouse and check the appropriate box under number 3 below.

A.



Cut here and give the bottom portion of certificate to your employer. Keep the top portion for your records.

Form **L-4**

Louisiana
Department of
Revenue

Employee's Withholding Certificate

1. First name and middle initial

Last name

2. Social security number

3. Select one:

☐ No deduction ☐ Single or married filing separately ☐ Married filing jointly, qualifying surviving spouse, or head of household

4. Home address (number and street or rural route)

5. City

State

ZIP

6. Total number of deductions claimed in Block A

6.

7. Adjustments. Enter any increase or decrease in the amount of tax to be withheld each pay period. Decreases should be indicated as a negative amount and cannot result in an amount less than zero to be withheld each pay period.

7.

I declare under the penalties imposed for filing false reports that the number of deductions claimed on this certificate do not exceed the number to which I am entitled.

Employee's signature

Date

The following is to be completed by employer.

8. Employer's name and address

9. Employer's state withholding account number



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					
Document Number (if any)		☐ Check here if you used an alternative procedure authorized by DHS to examine documents.			
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			Employer's Business or Organization Address, City or Town, State, ZIP Code		

For reverification or rehire, complete [Supplement B, Reverification and Rehire](#) on Page 4.

Jason Thompson – Chief of Staff
jasonthompson@opsb.net



Phone: 318-432-5206
1600 N. 7th St. West Monroe,

SEXUAL MISCONDUCT DISCLOSURE STATEMENT

As required by Louisiana Revised Statute 17:81:9 (Act 723), the applicant authorizes all previous employers to disclose and all information in the applicant's personnel file related to instances of sexual misconduct with students committed by the applicant. The applicant releases previous and current employers from Liability for providing the requested information to the Ouachita Parish School System.

- I have read and understand the above statement.
- I also understand that I cannot be considered for employment in the Ouachita Parish School System unless this form is signed.
- Once this form has been signed, the applicant may be hired on a conditional basis pending the review of any information obtained.
- I agree that a copy of this form will be sent to each of my previous employers. Each completed form received will be placed in my personnel file.

Full Legal Name: _____

Date of Birth: _____ Social Security Number: _____

Signature

Date

.....
This section to be completed by previous employer.

Name of School System: _____

_____ There is no one in our system by the name, social or birth date provided above.

_____ There is no information in the employee's file indicating sexual misconduct.

_____ I have attached documentation regarding sexual misconduct.

Please complete and send this form within 20 business days to Aletha Thompson or Morgan Futch. You can fax it to 318-432-5222 or mail it to 1600 N. 7th St. West Monroe, La 71291.

Signature/Title

Date

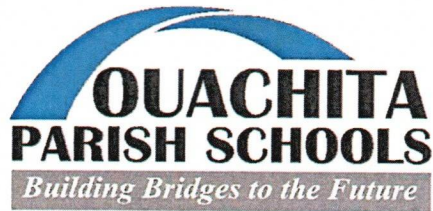
FULL NAME: _____ SOCIAL SECURITY NUMBER: _____

If you have ever worked in a school system before, public or private, in any form please fill out the section below. If you have not please skip to the bottom to sign and date.

SCHOOL SYSTEM	SCHOOL NAME	STATE	JOB TITLE	GRADE/SUBJECT	DATES EMPLOYED	TOTAL # OF YEARS

SIGNATURE

DATE



OUACHITA PARISH SCHOOL BOARD RULES OF CONDUCT FOR SUBSTITUTES

- No cellphone usage during school hours.
- No exchanging phone numbers with students.
- No texting or calling students.
- No taking pictures of students with cell phones or cameras.
- No playing on the computers during school hours.
- Control of the class will be maintained. Do not allow the students to act unruly.
- No tobacco usage during school hours.
- No liquor at school or coming to school under the influence or liquor allowed.
- The use of or possession of drugs or attempt to take part in the sale or illegal handling of drugs is strictly prohibited.
- The removal or property belonging to the school board or willful destruction of school property is prohibited.
- No sleeping or napping during school hours.
- Fighting or any other attempt to threaten or injure another person is not allowed.
- No fraternizing with school employees or sexual harassment will be allowed.
- No profanity is allowed.

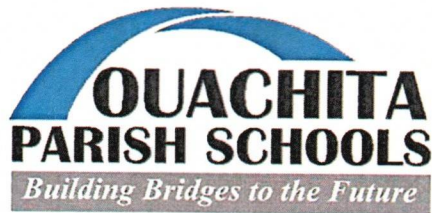
I understand that if I violate the rules of conduct listed above, that I will be removed from the active substitute list.

I also understand that substitutes are not permanent employees and are assured of employment after the customary breaks, therefor substitutes are not eligible or unemployment benefits.

Signature

Printed Name

Date



I, _____, understand the following bullet points:

- That I will be taken off the substitute list if I fail to respond to work within 45 days from the date of hire. I understand once I am removed I will have to go through the hiring process again.
- That the Substitute office will regularly check to see if I put myself on reduce call mode or reject calls to work. If this is the case and I have not worked with in 30 days I will be removed from the sub list. I understand once I am removed I will have to go through the hiring process again.
- That in the summer if I am a substitute teacher, I will receive a letter of assurance asking if I will be returning the next school year as a substitute teacher. Failure to sign and send back will cause me to be taken off the list. I understand once I am removed I will have to go through the hiring process again.
- That signing up to be a substitute teacher, substitute bus driver, bus aide, substitute cafeteria tech, Substitute maintenance/custodian, Substitute nurse or any other substitute position makes me **ineligible for unemployment benefits.**

Signature

Date



SEXUAL HARASSMENT

It is the policy of the Ouachita Parish School Board to maintain a working and learning environment for its employees and students that provides for fair and equitable treatment, including freedom from sexual harassment. It is prohibited for any employee or student, male or female, to harass another employee or student by making unwelcomed sexual advances for sexual favors, engaging in other verbal and/or physical conduct of a sexual nature where:

- Submission to or rejection of such conduct is used as a basis for employment or academic decisions
- Such conduct creates an intimidating, hostile, or offensive working or learning environment.
- Submission to such conduct is made wither explicitly or implicitly a term of condition of the individual's employment or participation in school programs.

Any employee or student who believes that he/she has been subjected to sexual harassment should file a written complaint of the allege act immediately to the Principal or Immediate Supervisor. The Principal or Immediate Supervisor will then contact the Chief of Staff or Director of Child Welfare in the case of a students. If the complaint is against the Superintendent, it shall be filed with the School Board President.

The question of whether a particular action or incident is prohibited behavior requires a determination based on all the available facts in the matter, a written report shall be filed at the conclusion of any investigation of sexual harassment regardless of the investigation.

Any administrator, teacher, other employee, or student who is found after appropriate investigation to have engaged in sexual harassment of another employee or student will be subject to disciplinary action appropriate to the offense from a warning up t expulsion or discharge.

Any individual filling a sexual harassment complaint is assured that he/she will be free from any retaliation for such a complaint. Retaliators will be subject to discipline up to and including expulsion and discharge.

Signature

Printed Name

Date

Mandatory Trainings:

Trainings that must be completed by
ALL EMPLOYEES: FULLTIME, SUBS OR CONTRACT.
You have 30 days from the day you start working
to have them completed.

1. Bully Awareness
2. Suicide Prevention
3. Cybersecurity Awareness
4. Ethics training
5. Preventing Sexual Harassment
6. Mandatory Reporter

You can access these training courses from the link below:

<https://www.opsb.net/employees/annual-mandatory-training>

Click on the name of the training for specific details for completing the training and what is required to submit to our office or in the Employee Records portal.

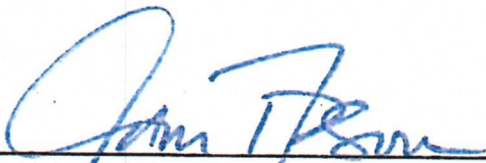
Once you have completed these trainings turn the certificate or the completion page to
Amanda Hammonds at ahammonds@opsb.net

Mandatory Training Signature Page:

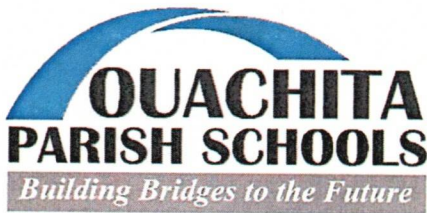
I, _____, understand that anyone being paid by Ouachita Parish Schools must complete the listed mandatory trainings. I also understand I have 30 days from the date of hire to have them completed or turned in. If they are not completed in time I understand I will not be able to work.

Signature

Date



Chief of Staff Jason Thompson



Employee Participation in 403(b) and 457 Investment Programs

As a Substitute or Contract Employee of the Ouachita Parish School Board substitute or contract employee that is not getting a retirement check monthly from TRSL, you are required to participate in the School Board's 457 investment programs. The School Board does not contribute to the 403(b) or 457 investment programs. The programs are funded totally by employee contributions. Employee contributions are deducted monthly from the employee's paycheck. Once you are hired full-time or quit you can contact payroll and request to pull your money out. This money cannot be rolled over into your full-time retirement, it can only be pulled out. If you pull this money out while you are subbing, you cannot sub for a year from the date of the withdrawal.

The next pages in this packet is the forms for the 457 Program, please only complete the seconds that are marked with an asterisk. You may keep pages 5-7 for your records.

I have read the above and understand I am required to pay into the Nationwide Retirement,

Signature

Printed Name

Date

OUACHITA PARISH SCHOOL BOARD
JOB DESCRIPTION

TITLE: **Substitute Teacher**

QUALIFICATIONS:

Must be at least 21 years of age.

Must complete required District and State credentialing requirements (Background check, fingerprinting)

Additional criteria as the Board may establish

REPORTS TO: Onsite Administrator

JOB GOAL: Manage student learning in accordance with the goals and directives of the schools and states.

PERFORMANCE RESPONSIBILITIES:

The minimum performance expectations include, but are not limited to, the following essential functions:

- Maintains and respects confidentiality of student and school personnel information;
- Maintains discipline and classroom control that fosters a safe and positive learning environment for all students and staff in accordance with school and county policies;
- Ensures the adequate supervision to assure health, welfare, and safety of all students;
- Takes all necessary and reasonable precautions to protect students, equipment, materials and facilities;
- Reports to office upon arrival at school; checks mailbox of absent teacher for materials requiring immediate attention; requests clarification of school rules and procedures, if necessary;
- Reports all student injuries, accidents, illnesses, and discipline problems to the appropriate authority immediately or as soon as is reasonably possible;
- Implements lesson plans, while ensuring the integrity of academic time and in a manner which motivates students to learn and participate;
- Organizes students for effective instruction;
- Dismisses all students from the classroom before leaving the building;
- Completes a Substitute Teacher Report Form for the regular classroom teacher;
- Collects and places students' papers in regular teacher's desk;
- Returns instructional materials, equipment, and keys to proper place;
- Complies with and supports school and state regulations and policies;
- Performs other related duties as assigned by building administrator(s) in accordance with school/state policies and practices.

KNOWLEDGE, SKILLS AND ABILITIES

Must be able to follow oral and written directions and have the ability to establish effective working relationships with staff and students. Ability to maintain effective classroom management strategies.

PHYSICAL DEMANDS/REQUIREMENTS

- Duties performance typically in school settings to include: classrooms, gymnasium, cafeteria, auditorium, and recreational areas.

- Frequent walking, standing, stooping, lifting, up to approximately 30 pounds and occasional lifting of equipment and/or materials weighing up to 40 pounds may be required. Other physical activities may be required.
- Vocal communication is required for expressing or exchanging ideas by means of the spoken word; hearing is required to perceive information at normal spoken word levels.
- Visual acuity is required for preparing and analyzing written or computer data, determining the accuracy and thoroughness of work, and observing general surroundings and activities.
- The worker is subject to inside and outside environmental conditions, noise and hazards.
- Occasional movement of students by wheelchairs and other mechanical devices may be required.
- Regular instruction to special needs children may be necessary.
- Daily personal and close contact with children to provide classroom management and learning environment support is required on assigned days.
- Regular contact with other staff members and building administrator(s) is required on assigned days as a substitute.
- Perform all other duties or responsibilities not listed as delegated by the Principal of the school and OPSB policy.

While the operation of the Ouachita Parish School Board and its schools is governed by the provisions of this and all other policies, as well as the procedures of the individual schools, no policy manual can list each and every instance of misconduct that is precluded. Accordingly, employees are cautioned that the appropriateness of certain action or behavior must necessarily be dictated by the nature of the position held by the employee and commonsense. By virtue of one's education and experience, an employee knows and understands that certain actions or conduct are unacceptable even in the absence of formal policy. For instance, without the need of a specific prohibition or warning, a classroom teacher should be aware of the impropriety of certain practices such as leaving students unattended, using profanity or sexually suggestive language or bringing a firearm onto campus. Such conduct constitutes both incompetence and willful neglect of duty and will result in the imposition of discipline up to and including termination.

TERMS OF EMPLOYMENT: as stated

ACCOUNTABILITY:

Performance of this job will be evaluated in accordance with provisions of the Louisiana Accountability System of the board's policy on Evaluation of Personnel.

The Superintendent reserves the right to review, revise, update or change the job and any/all duties due to changes in job content, organizational structure, or state or federal laws.

I certify that I have reviewed and understand each requirement and that I am capable of meeting each and every requirement.

Signature of Employee

Date

Name of Employee (PLEASE PRINT)

Last Four SS#

Signature of Evaluator

Date



Nationwide®

NACo Participation Agreement for 457(b) and 401(a) Plans

Page 1 of 7

Personal Information

457(b) Employer Name: DPSB 457(b) Employer ID: 1018173
401(a) Employer Name: _____ 401(a) Employer ID: _____
Name: _____
Date of Birth: _____ SSN: _____ Gender: ☐ Male ☐ Female
Street Address: _____
City: _____ State: _____ ZIP: _____
Home Phone: _____ Work Phone: _____
Hire Date: _____ Email: _____
How would you like to be contacted if additional information is required? ☐ Phone ☐ Email

Paperless Delivery Consent

By providing your email address you are consenting to electronic (paperless) delivery of documents related to your retirement plan, e.g. - statements, confirmations, terms, agreements, etc. If you would like to receive the above referenced documents in paper form via U.S. Mail you can do so by contacting Customer Service at 1-877-677-3678 and requesting paper. You may opt out of electronic delivery of your plan related documents at any time by logging in to your account at nrsforu.com as well. There is no additional cost to receive documents in paper format via U.S. Mail.

Contribution Summary & Payroll Frequency

457(b) Pre-Tax	\$ _____	OR	_____ %*	*Check with your employer on whether your plan offers deferrals in percentages, dollar amounts or both.
457(b) Roth**	\$ _____	OR	_____ %*	**May not be offered by your plan. Roth contributions are made on an after-tax basis.
401(a) Pre-Tax***	\$ _____	OR	_____ %*	***Employee Mandatory Contribution (401(a) only) is a one time election stated in the Plan Document. This election is irrevocable and must be made before the participant's first entry date.
Total	\$ _____	OR	_____ %	

Payroll Frequency: ☐ Weekly ☐ Bi-Weekly ☒ Monthly ☐ Semi-Monthly ☐ Other: _____

Start Contribution On (Pay Period): _____

Automatic Contribution Increase Election (optional)

NOTE: This election is voluntary and is only available if permitted by your plan.

☐ I elect to participate in an annual automatic contribution increase.

If selected, this increase will automatically occur annually as soon as administratively feasible for the date selected below. Increases can only occur for money source(s) (Pre-Tax and Roth) and mode(s) (\$ or %) that you are currently contributing. Please do not select a date of 02/29; if selected, Nationwide will process on 02/28.

457(b) Pre-Tax Increase \$ _____ OR _____ %

457(b) Roth Increase \$ _____ OR _____ %

Increase Contribution Annually on: _____ (MM/DD)

Additional information regarding the automatic contribution increase option can be found in the attached Memorandum of Understanding.

☐ I elect to stop my annual automatic contribution increase.



Beneficiary Designation

☐ Check here if this is a change of beneficiary. (Beneficiaries listed below replace any prior designation)

NOTE: Percentage split must total 100% for each category of beneficiary. If you designate a single primary or contingent beneficiary and do not list a percentage, it will be designated as 100%.

If additional space for beneficiaries is required, attach additional sheets and mark this box: ☐

Primary Beneficiary(ies) (must total 100%):

1. Full Name: _____ Allocation: _____%
 Relationship: _____ SSN: _____ Date of Birth: _____
 Address: _____ Phone: _____
2. Full Name: _____ Allocation: _____%
 Relationship: _____ SSN: _____ Date of Birth: _____
 Address: _____ Phone: _____
3. Full Name: _____ Allocation: _____%
 Relationship: _____ SSN: _____ Date of Birth: _____
 Address: _____ Phone: _____
4. Full Name: _____ Allocation: _____%
 Relationship: _____ SSN: _____ Date of Birth: _____
 Address: _____ Phone: _____

Contingent Beneficiary(ies) (must total 100%):

1. Full Name: _____ Allocation: _____%
 Relationship: _____ SSN: _____ Date of Birth: _____
 Address: _____ Phone: _____
2. Full Name: _____ Allocation: _____%
 Relationship: _____ SSN: _____ Date of Birth: _____
 Address: _____ Phone: _____
3. Full Name: _____ Allocation: _____%
 Relationship: _____ SSN: _____ Date of Birth: _____
 Address: _____ Phone: _____
4. Full Name: _____ Allocation: _____%
 Relationship: _____ SSN: _____ Date of Birth: _____
 Address: _____ Phone: _____

Funding Options

Please find below the standard investment lineup for NACo, your plan may or may not have adopted all investment options listed. To see your plan's current lineup and performance, please refer to the fund performance page at nrsforu.com or call us at 1-877-677-3678.

Asset Allocation - NCIT index Funds

- ____ % NCIT Index 2025 Fund (Class B)
- ____ % NCIT Index 2030 Fund (Class B)
- ____ % NCIT Index 2035 Fund (Class B)
- ____ % NCIT Index 2040 Fund (Class B)
- ____ % NCIT Index 2045 Fund (Class B)
- ____ % NCIT Index 2050 Fund (Class B)
- ____ % NCIT Index 2055 Fund (Class B)
- ____ % NCIT Index 2060 Fund (Class B)
- ____ % NCIT Index 2065 Fund (Class B)
- ____ % NCIT Index Retirement Fund (Class B)

Asset Allocation - Income America 5ForLife Funds

- ____ % Income America 2025 Fund - 5ForLife
- ____ % Income America 2030 Fund - 5ForLife
- ____ % Income America 2035 Fund - 5ForLife
- ____ % Income America 2040 Fund - 5ForLife
- ____ % Income America In Retirement Fund Fee (Class 5ForLife)
- ____ % Income America Balanced Fund Fee (Class 5ForLife N)

Manage for me

- ____ % ManageForMe Conservative Fund (SVC Class)
- ____ % ManageForMe Moderately Conservative Fund (SVC Class)
- ____ % ManageForMe Moderate Fund (SVC Class)
- ____ % ManageForMe Moderately Aggressive Fund (SVC Class)
- ____ % ManageForMe Aggressive Fund (SVC Class)

Large Cap

- ____ % Edgar Lomax Value Fund
- ____ % Fidelity Contrafund
- ____ % Fidelity® OTC
- ____ % Nationwide GQG US Quality Equity Fund (Class A)
- ____ % Nationwide Fund (Institutional Service Class)
- ____ % Nationwide Large Cap Growth Portfolio
- ____ % Nationwide S&P 500 Index Fund (Institutional Service Class)
- ____ % NCIT AB Large Cap Growth Fund (Class B)
- ____ % NCIT American Century Equity Income Fund (Class B)
- ____ % NCIT ClearBridge Large Cap Value Fund (Class B)
- ____ % Parnassus Core Equity (Investor Class)
- ____ % SEI S&P 500 Index Fund (Class F)

Mid Cap

- ____ % Nationwide Mid Cap Market Index Fund (Class A)
- ____ % NCIT Allspring Discovery Fund (Class B)
- ____ % NCIT MFS Mid Cap Value Fund (Class B)

Small Cap

- ____ % Nationwide Small Cap Index Fund (Class A)
- ____ % Nationwide Small Company Growth Fund (Institutional Service Class)
- ____ % Nationwide Variable Insurance Trust: Multi-Manager Small Company Fund (Class I)
- ____ % NCIT American Century Small Cap Income Fund (Class B)
- ____ % Neuberger Berman Genesis Fund (Trust Class)

Balanced

- ____ % Fidelity Puritan Fund

International

- ____ % American Funds New World (R4)
- ____ % Nationwide Global Sustainable Equity Fund (Institutional Service Class)
- ____ % Nationwide International Index Fund (Class A)
- ____ % NCIT Janus Henderson Overseas Fund (Class B)

Specialty

- ____ % Cohen & Steers Real Estate Securities Fund, Inc (Class A)

Bonds

- ____ % Loomis Sayles Limited Term Government and Agency (Class Y)
- ____ % Lord Abbett High Yield Fund (Class R5)
- ____ % Nationwide Amundi Strategic Income Fund (Class A)
- ____ % Nationwide Bond Index Fund (Class A)
- ____ % Nationwide Loomis Core Bond Fund (Institutional Service Class)
- ____ % PIMCO International Bond Fund (US Dollar-Hedged) (Class A)

Fixed/Cash

- ____ % Invesco Short Term Investment Trust Treasury Portfolio (Institutional Class)
- ____ % Nationwide Fixed Account
- ____ % Nationwide Government Money Market Fund (Investor Shares)

100 % Total for both columns must equal 100%

Authorization



- ☐ Please send me a copy of the Informational Brochure/Prospectus(es).
- ☐ Please contact me regarding transferring my other pre-tax retirement plans.
- ☐ Please send me forms regarding the Catch-Up Provision.

I authorize my Employer to make the contribution(s) to the Plan in the amounts I have designated above. The contribution(s) will continue until otherwise authorized in accordance with the Plan. The withholding of my contribution(s) amount by my Employer and its payment to the designated investment option(s) will be reflected as early as administratively practicable following the execution of this application by the Public Sector Service Center in conjunction with the set-up time required by my payroll center; however, new deferrals and changes to my deferral amount cannot be effective until the first payroll of the next month after such election is made. The contribution(s) is to be allocated to the funding options in the percentages indicated above. I understand some investment options may impose a short-term trading fee. I understand I should read the fund prospectuses carefully.

I have read and understand the terms contained in this form, including the attached Memorandum of Understanding, which is incorporated herein.

I accept these terms and understand that these terms do not cover all the details of the Plan or products.

Signature: _____ Date: _____

Retirement Specialist Name (Print): Megan Wyatt Agent #: _____

Things To Remember

- ☐ Complete all of the sections on the Participation Agreement that apply to your request.
- ☐ Remember to have the allocation of your funding options total 100%, in whole percentages, when completing the Funding Options section. If allocations do not total 100%, the remaining amounts will be considered to be not in good order, and you agree the unallocated portion will be allocated to the plan's default investment option.
- ☐ For your beneficiary designation, the percentage split must total 100% for each category of beneficiary.
- ☐ Complete the Authorization section, and remember to sign and date this Participation Agreement.
- ☐ Enclose the completed Participation Agreement, and any other documentation in the business reply envelope included with this booklet.
- ☐ Your Plan may permit you based on eligibility to contribute additional funds as a "catch-up" contribution during the last three years preceding the normal retirement age under the Plan. If you would like to receive paperwork to take advantage of the catch-up provision, please check the appropriate box in the authorization section on page four.
- ☐ Your employer will specify the amount of 414(h) Pickup contributions (401(a) only). Generally, these contributions are expressed as a percentage of pay. If an amount is specified, all eligible employees are required, as a condition of employment to make this contribution.

Form Return

Mail: Nationwide Retirement Solutions
PO Box 182797
Columbus, OH 43218-2797

Email: rpublic@nationwide.com

Fax: 877-677-4329

Please note that the information provided on this Participation Agreement will supercede any prior information provided, such as allocations, contribution amounts, contribution types (except Mandatory Employee Contribution) and/or beneficiary information.



The purpose of the Memorandum of Understanding is to make you aware of some of the highlights, restrictions and costs of your Plan. It is not intended to cover all the details of the Plan and should not be relied upon in making decisions about Plan benefits. You should refer to the Plan Document for specific details about the Plan's provisions and the prospectuses and other documentation for the Plan's underlying investment options.

457(b) PLANS

1. The total annual contribution amount to all 457(b) plans is the lesser of the maximum annual 457(b) contribution limit or 100% of the participant's includible compensation. This amount may be adjusted annually. More information on the maximum contribution limits can be found at irs.gov. Under certain circumstances, additional amounts above the limit may be contributed to the Plan if (1) the participant attains age 50 or older during the current calendar year, or (2) the participant is within three years of the Plan's Normal Retirement Age and did not contribute the maximum amount to the 457(b) Plan in prior years. The Plan Document provides additional details about contribution limits. Contributions in excess of maximum amounts are not permitted and will be reported as taxable income when refunded. It is the participant's responsibility to ensure contributions to all 457(b) plans in which the participant participates, regardless of employer, do not exceed the annual limit.
2. Enrollment or contribution changes will be made according to your plan document provisions, following receipt of the participant's request. The employer's processing schedule will determine the actual effective date of the contribution. It is the Plan Sponsor's/Pay Center's responsibility to ensure deferrals do not commence too early.
3. If the Plan permits designated Roth contributions, these contributions are made on an after-tax basis, which means they will not be subject to income taxes when distributed at a later time. As opposed to the withdrawal of earnings on pre-tax contributions, though, the earnings on designated Roth contributions are generally not subject to future taxes as long as the distribution from the Roth account satisfies the requirements to be a "qualified distribution." In order to be a qualified distribution, the distribution must be made five or more years after January 1 of the first year the participant made Roth contributions to the Plan and must be made on or after the attainment of age 59½, the participant's death, or the participant's disability. If the participant previously established another designated Roth account in another plan and is able to roll the funds from this Plan to the other plan, the five-year period would begin to run from January 1 of the year of the first contribution to a designated Roth account. A non-qualified Roth distribution may result in an additional 10% early withdrawal tax on the portion of the distribution includible in gross income if made from rollovers to this Plan from a qualified plan or a 403(b) plan, and no statutory exceptions apply. Please note that once made, contributions and/or rollovers to a Roth account may not be reversed. In the event the participant desires to make contribution changes, only future contributions and/or rollovers can be redirected (contributed as pre-tax funds).
4. The Plan Document governs when distributions may be made from the Plan. In general, distributions may be made from a 457(b) plan only upon separation from service, upon attainment of age 70½ or lower if elected by your Plan Sponsor, or upon the death of the participant. Section 457(b) plans can also permit withdrawals from the Plan (even if the participant is still employed) in cases of an unforeseeable emergency approved by the Plan; when taking a loan, or for a one-time in-service withdrawal if the participant's account value is \$5,000 or less and the participant has not contributed to the Plan for two or more years. All withdrawals of funds must be in compliance with the Internal Revenue Code (the "Code") and any applicable regulations as well as the Plan Document, which the participant should consult to confirm which distribution opportunities are available.
5. Contributions, in the form of salary reductions, will be made until I notify NRS or my Plan Sponsor otherwise. Once notification is received, salary reductions will be changed as soon as administratively feasible. NRS will invest contributions received from the Plan Sponsor as soon as administratively feasible.

401(a) PLANS

1. The annual defined contribution plan limit to all 401(a) plans is the lesser of the IRS maximum 415 limit, or 100% of my eligible compensation. This amount may be adjusted annually. More information on the maximum contribution limits can be found at irs.gov. Current or future participation in additional retirement plans, such as 403(b) and/or 401(a) plans, may affect the maximum annual contribution limit under this 401(a) plan.
2. The Plan Document governs when distributions may be made from the Plan. In general, distributions may be made only upon separation from service or upon the death of the participant. Some plans may also permit distribution upon reaching normal retirement age as defined in the Plan Document, upon a financial hardship approved by the Plan, upon disability or when taking a loan. All withdrawals of funds must be in compliance with the Code and any applicable regulations as well as the Plan Document, which the participant should consult to confirm which distribution opportunities are available. An additional early withdrawal tax of 10% may apply in some circumstances. It is strongly recommended that the participant consult with his/her tax advisor prior to requesting a distribution.
3. 414(h) Mandatory Employee Contributions - Your employer will specify the amount of these contributions if they are required by the Plan. Generally, these contributions are expressed as a percentage of pay. If an amount is specified, all eligible employees are required, as a condition of employment, to make this contribution to the Plan. These contributions will not be included in your taxable gross income; however, they do come out of your paycheck. The tax on these contributions will be deferred until benefits are distributed. Other plans may permit the participant to make a one time irrevocable election to contribute a percentage of compensation to the Plan prior to his/her Plan entry that cannot be modified later. The participant should consult the Plan Document for specific contribution provisions.

ALL PLANS

1. Participation in any of the employer's plans is governed by the terms and conditions of the Plan Document which should be consulted for plan details. Fund prospectuses are available upon request at nrsforu.com or by calling 877-677-3678.
2. Generally, you must begin taking distributions from the Plan no later than April 1 following the year you reach age 73. If you continue to work for this employer beyond age 73, (75 for an individual who attains age 74 after December 31, 2032), generally, your distributions must begin no later than April 1 following the year you separate from service or retire. Please consult the Plan Document for additional information. All distributions are taxable as ordinary income and subject to income tax in the year received. You must take distributions in a manner that satisfies the minimum distribution requirements of Section 401(a)(9) of the Code, which currently requires benefits to be paid at least annually over a period not to extend beyond your life expectancy. Failure to meet minimum distribution requirements may result in the payment of a 25% federal excise tax.
3. Any beneficiary designation I made on this form will supersede any prior beneficiary designation and shall become effective on the date accepted by the Plan, provided that this designation is accepted by the Plan prior to my death. Further, any benefits payable at my death shall be paid in substantially equal shares to my beneficiaries unless I specify otherwise. My death benefits will be paid first to my Primary Beneficiaries. If any of my Primary Beneficiaries predecease me, then my death benefits will be paid to the remaining Primary Beneficiaries. Contingent Beneficiaries will only receive benefits if no Primary Beneficiary survives me. If no beneficiary designation is on file, benefits will be paid as set forth in the Plan Document. If I participate in both a 457(b) plan and a 401(a) plan administered by NRS, I understand my beneficiary designations made on this form will apply to both plans unless I have indicated otherwise.
4. Disclaimer for Community and Marital Property States: If the participant resides in a community or marital property state, the participant's spouse may have a property interest in the participant's Plan account and the right to dispose of the interest by will. Therefore, NRS disclaims any warranty as to the effectiveness of the participant's beneficiary designation or as to the ownership of the account after the death of the participant's spouse. For additional information, please consult your legal advisor to learn more about how your beneficiary designation may be affected by community or marital property state law.
5. Participants must notify NRS of any address changes, beneficiary changes, contribution changes, allocation changes or errors on the participant's account statement.

6. Participants will receive a statement of their account quarterly.
7. All Plan transactions initiated using the telephone will be recorded for the participant's protection.

INVESTMENT OPTIONS

1. Participant contributions will be invested pursuant to the participant's selection of funding options specified on the Participation Agreement.
2. NRS will permit participants and beneficiaries to exchange amounts among the Variable and Fixed investment options as frequently as permitted by the Plan, subject to the limits and rules set by each Fund and the Annuity Contracts. Changes may be made by calling 877-677-3678 or by logging on to nrsforu.com. Investment options may be periodically changed or restricted, and may vary by the source of the money invested.
3. Transfers between investment options are provided for under the Plan subject to limitations or restrictions (including redemption fees), if any, as imposed by the investment providers. Some mutual funds may also impose a short term trading fee. I understand that any information regarding limitations or restrictions as they apply to the Plan may be obtained from the Plan Administrator. Participants should read the underlying mutual fund prospectuses carefully.
4. The Net Asset Value of a mutual fund changes on a daily basis and there is no guarantee of principal or investment return.
5. If the participant selects an investment option that is closed or unavailable, the money will be invested in the plan's default investment option. If participants elect a total investment allocation percentage that is less than 100%, the unallocated difference will be invested in the plan's default option. If the participant elects a total investment allocation percentage greater than 100%, the deferral election will be rejected and the participant's investment option selections will not be processed.
6. The Plan may impose a Plan administration fee or investment management fees. Fees can vary depending on the mutual funds in which the participant invests. For more information regarding fees, please call 877-677-3678.

NATIONWIDE LIFE FIXED ACCOUNT

1. A guaranteed interest rate is declared quarterly and credited daily, which is not lower than the minimum annual rate.
2. Nationwide may earn a spread on assets held in the Nationwide Fixed Account, which is reflected in the crediting rate. The spread represents the difference between what Nationwide earns on investments and what it credits to the Fixed Account as interest.
3. Exchanges or transfers may be made based upon one of the following options as chosen by your employer:
 - a. Exchanges and/or transfers of money from the Fixed Account may be made no more than twice a year and may not exceed 20% of the participant's Fixed Account value. Once the 20% limit has been reached, no further exchanges/transfers will be permitted out of the participant's Fixed Account during the remainder of the calendar year. If the Fixed Account value is less than or equal to \$1,000, the participant can exchange/transfer up to the entire account value. Each exchange/transfer will count toward the limitation of two exchanges/transfers out of the Fixed Account per year. Additionally, a five-year Exchange/Transfer election allows for the systematic movement of 100% of the participant's account value out of the Fixed Account on a monthly basis over a five-year period. If elected, the participant cannot defer, exchange, or transfer into his/her Fixed Account during the five-year term without canceling this election.

-OR-

- b. Exchanges and/or transfers from the Fixed Annuity may be made up to 100% of the participant's account value. The total of all participant exchanges and/or transfers cannot exceed 12% of the total amount held in the Deposit Fund for the employer under the Fixed Account as of December 31 of the previous calendar year. Once this aggregate limit is met, no further exchanges or transfer into any participant's Fixed Account will be permitted.

Exchange: An exchange is the movement of money between the Nationwide Life Fixed Account and Variable Annuity options and/or between funds in the Variable Annuity option.

Transfer: A transfer is the movement of money between product providers within the same plan.

NATIONWIDE LIFE VARIABLE ANNUITY CONTRACT

1. I understand that a Variable Account Charge is deducted daily from the Variable Account. The Variable Account Charge is deducted daily in an amount not to exceed the following schedule:

Plan Assets	Variable Account Charge
0 - \$10 million	0.95%
\$10 - \$25 million	0.90%
\$25 - \$50 million	0.80%
\$50 - \$100 million	0.65%
\$100 - \$150 million	0.50%
\$150 million	0.40%

2. I understand that retirement income payments and termination values (if any), provided by the contract are variable when based on the investment experience of a separate account and are not guaranteed as to the dollar amount.

INCOME AMERICA 5FORLIFE™

Income America 5ForLife is a series of investment portfolios, including target date funds, that provide guaranteed lifetime income. The income guarantee is based on the income base at age 65, which is set to the greater of the highest annual locked-in market value* or the contributions (as adjusted for withdrawals) to date. The market value of the account is never guaranteed and fluctuates based on investment performance. While withdrawals from the market value of the account can be made at any time without any fees or penalties, doing so will reduce the income guarantee proportionally. The income base is never available for withdrawal but is only used for calculating income. You will be able to elect to receive income any time after age 65. If you elect the joint option, your payout will be lower than 5%, and is dependent on your age and your spouse's age. If you withdraw more than the guaranteed annual income in any year, your income base and future guaranteed annual income payments will decrease. However, if your required minimum distribution exceeds your guaranteed income amount, your income base will not be affected, and your payments will not be lowered. When you turn age 65 and at the time you elect to receive income, you must be invested in the 5ForLife In Retirement portfolio. Investment exchanges will be implemented automatically from any other 5ForLife portfolio to the 5ForLife In Retirement portfolio, except please insert the appropriate names for the MAS and BALANCED funds. If you make investment exchanges out of any 5ForLife portfolio into a non-5ForLife portfolio, you may not make an investment exchange back into any 5ForLife portfolio within 90 calendar days. Guarantees are subject to the claims-paying ability of the issuing companies. *The highest Income America account value recorded on the participant's birthday.

AUTO INCREASE

I understand that the participant elected automatic contribution increase option is only available if offered by the Plan and, if offered, will not take place until I elect this option. By selecting the participant elected automatic contribution increase option, my payroll contributions will automatically increase annually for the money source(s), the date and by the dollar or percentage amount selected. I may stop the participant elected automatic contribution increase at any time by calling 877-677-3678 completing a new Participation Agreement, or accessing nrsforu.com. Increase requests that do not match the current source and mode as I am currently contributing will not be processed. A selected date of 02/29 will be changed to 02/28.

MUTUAL FUND SERVICE FEE PAYMENT DISCLOSURE

Nationwide Retirement Solutions, Inc. and its affiliates (Nationwide) offer a variety of investment options to public sector retirement plans through variable annuity contracts and trust or custodial accounts. Nationwide may receive service fee payments from mutual funds or their affiliates in connection with the processing of transactions and distribution of those investment options. For more detail about the service fee payments Nationwide may receive, please visit nrsforu.com.

ENDORSEMENT DISCLOSURE

Nationwide Retirement Solutions, Inc. and Nationwide Life Insurance Company have endorsement relationships with the National Association of Counties. More information about the endorsement relationships may be found online at nrsforu.com.

CONSENT TO ELECTRONIC PAPERLESS DELIVERY AND ACCESS

By providing your email address here, you are agreeing and consenting to receive and view plan benefit statements, correspondence and confirmations, and other communications electronically. These materials will be provided through an email message notifying you that electronic documents are available online for you to view and print. This replaces all written communication associated with your Retirement Plan(s) serviced by Nationwide and you will no longer receive these documents via U.S. Mail. By providing your consent to electronic delivery, you are acknowledging and confirming that you are consenting to receive Plan Communications electronically, as they are now available or as they may be required or become available in the future and that you have access to view and print your documents electronically from the website and to save them from your computer or other electronic device. If you would like to receive the above referenced documents in paper form via U.S. Mail you can do so by contacting Customer Service at 877-677-3678 and requesting paper. You may opt out of electronic delivery of your plan related documents at any time. There is no additional cost to receive documents in paper format via U.S. Mail.

CHANGING YOUR EMAIL ADDRESS AND YOUR PAPERLESS DELIVERY PREFERENCES

You are able to update your email address or change your Paperless Preferences anytime either on the website or via Customer Service.

YOUR RIGHT TO REVOKE CONSENT

You have the right to revoke your consent to receive documents electronically. Your consent shall be effective until you revoke it by changing your delivery preferences via Customer Service or on the website by selecting U.S. Mail delivery.

**LOUISIANA WORKERS' COMPENSATION SECOND INJURY BOARD
POST-HIRE/CONDITIONAL JOB OFFER KNOWLEDGE QUESTIONNAIRE**

EMPLOYEE: The intent of this questionnaire is to provide your employer with knowledge about any pre-existing medical condition or disability which may entitle your employer to reimbursement from the Louisiana Workers' Compensation Second Injury Board in the event you suffer an on-the-job injury.¹ This reimbursement in no way affects the benefits owed to you by your employer or its insurance company under the Louisiana Workers' Compensation Act. La. R.S. 23:1021-1361. However, your failure to answer truthfully and/or correctly to any of the question on this questionnaire may result in a forfeiture of your workers' compensation benefits.

In order for your employer to be considered for reimbursement from the Second Injury Board, it has to show that it knowingly hired or retained you with a pre-existing medical condition or disability. To establish its knowledge, your employer is requesting that this questionnaire be completed.

INSTRUCTIONS: Please answer ALL questions completely. If a response requires an explanation, please provide a brief description on the Explanation Page. If you have any questions or need help in answering the questions on this form, please ask for assistance from the Employer Representative signing this form.

NOTE: Since this questionnaire contains medical information, you can request that the form be kept CONFIDENTIAL and not made part of your personnel file. Please let your employer know that you want the completed questionnaire placed in a sealed folder for confidentiality purposes.

EMPLOYEE WARNING

**FAILURE TO ANSWER TRUTHFULLY AND/OR CORRECTLY TO ANY OF THE QUESTIONS ON THIS FORM MAY
RESULT IN A FORFEITURE OF YOUR WORKERS' COMPENSATION BENEFITS UNDER La. R.S. 23:1208.1.**

* Employee Signature: _____ Date: _____

Employer Representative Signature: _____ Date: _____

Employer Name: OPSB _____

Employee Name: _____

Date of Birth (mm/dd/yyyy): _____ Male: ☐ Female: ☐

Soc. Sec. # (last 4 digits only): _____

Home Address: _____

Telephone Number: (____) _____

¹ Under La. R.S. 23:1371(A), the purpose of the Second Injury Board is to encourage the employment, re-employment, or retention of employees who have a permanent partial disability.

Disease and Other Medical Conditions you currently have or have ever had.

For all conditions that you check yes, write a brief explanation on the Explanation Page.

[Please check the appropriate box next to each. Every illness/injury requires a Yes (Y) or No (N) answer.]

Y N	Y N	Y N	Y N
☐ ☐ Diabetes	☐ ☐ Cerebral Palsy	☐ ☐ Arthritis	☐ ☐ Heart Disease/Heart Attack
☐ ☐ Silicosis	☐ ☐ Tuberculosis	☐ ☐ Parkinson's	☐ ☐ Congestive Heart Failure
☐ ☐ Varicose Veins	☐ ☐ Multiple Sclerosis	☐ ☐ Brain Damage	☐ ☐ Vision Loss, one or both eyes
☐ ☐ Asbestosis	☐ ☐ Post Traumatic Stress	☐ ☐ Asthma	☐ ☐ Disability from Polio
☐ ☐ Hyperinsulinism	☐ ☐ Osteomyelitis	☐ ☐ Dementia	☐ ☐ Psychoneurotic Disability
☐ ☐ Alzheimer's	☐ ☐ Nervous Disorder	☐ ☐ Thrombophlebitis	☐ ☐ Ruptured or Herniated Disc
☐ ☐ Emphysema	☐ ☐ Muscular Dystrophy	☐ ☐ Arteriosclerosis	☐ ☐ Ankylosis or Joint Stiffening
☐ ☐ Hearing Loss	☐ ☐ Migraine Headaches	☐ ☐ Hodgkin's	☐ ☐ High/Low Blood Pressure
☐ ☐ COPD	☐ ☐ Mental Retardation	☐ ☐ Cancer	☐ ☐ Carpal Tunnel Syndrome
☐ ☐ Hypertension	☐ ☐ Kidney Disorder	☐ ☐ Double Vision	☐ ☐ Compressed Air Sequelae
☐ ☐ Head Injury	☐ ☐ Loss of Use of Limb	☐ ☐ Mental Disorders	☐ ☐ Disease of the Lung
☐ ☐ Epilepsy	☐ ☐ Seizure Disorder	☐ ☐ Hemophilia	☐ ☐ Coronary Artery Disease
☐ ☐ Stroke	☐ ☐ Sickle Cell Disease	☐ ☐ Bleeding Disorder	☐ ☐ Heavy Metal Poisoning

Surgical Treatment [Please check the appropriate box. Each illness/injury requires a Yes (Y) or No (N) answer.] For each Yes (Y) answer, please complete the information corresponding to the surgery on the right. Additional information can be provided on the Explanation Page, if necessary.

Y N

☐ ☐ Spinal Disc Surgery	Year (approximate if unsure) _____
☐ ☐ Spinal Fusion Surgery	Year (approximate if unsure) _____
☐ ☐ Amputated Foot	Left ☐ Right ☐ Year (approx. if unsure) _____
☐ ☐ Amputated Leg	Left ☐ Right ☐ Year (approx. if unsure) _____
☐ ☐ Amputated Arm	Left ☐ Right ☐ Year (approx. if unsure) _____
☐ ☐ Amputated Hand	Left ☐ Right ☐ Year (approx. if unsure) _____
☐ ☐ Knee Replacement	Left ☐ Right ☐ Year (approx. if unsure) _____
☐ ☐ Hip Replacement	Left ☐ Right ☐ Year (approx. if unsure) _____
☐ ☐ Other Joint Replacement	Joint _____ Year _____
☐ ☐ Other Surgical Procedure	Procedure _____ Year _____
☐ ☐ Other Surgical Procedure	Procedure _____ Year _____
☐ ☐ Other Surgical Procedure	Procedure _____ Year _____
☐ ☐ Other Surgical Procedure	Procedure _____ Year _____

* Employee Signature: _____ Date: _____

Employer Representative: _____ Date: _____

EXPLANATION PAGE

Please use the space below to explain the illnesses and/or conditions that you checked a Yes (Y) or any other medical conditions that may not be listed on this form. Ask your employer for additional copies of this page if needed.

CONDITION: _____ Year Diagnosed (approx): _____

Are you still treating for this condition? Yes ☐ No ☐

Are you taking medication for this condition? Yes ☐ No ☐

Do you have any permanent restrictions for this condition? Yes ☐ No ☐

Brief Explanation: _____

CONDITION: _____ Year Diagnosed (approx): _____

Are you still treating for this condition? Yes ☐ No ☐

Are you taking medication for this condition? Yes ☐ No ☐

Do you have any permanent restrictions for this condition? Yes ☐ No ☐

Brief Explanation: _____

CONDITION: _____ Year Diagnosed (approx): _____

Are you still treating for this condition? Yes ☐ No ☐

Are you taking medication for this condition? Yes ☐ No ☐

Do you have any permanent restrictions for this condition? Yes ☐ No ☐

Brief Explanation: _____

CONDITION: _____ Year Diagnosed (approx): _____

Are you still treating for this condition? Yes ☐ No ☐

Are you taking medication for this condition? Yes ☐ No ☐

Do you have any permanent restrictions for this condition? Yes ☐ No ☐

Brief Explanation: _____

* Employee Signature: _____ Date: _____

Employer Representative: _____ Date: _____

Please answer the following questions.

1. Has any doctor ever restricted your activities? Yes ☐ No ☐

If "Yes," please list the restrictions: _____

Were the restrictions: Permanent ☐ Temporary ☐

Are your activities currently restricted? Yes ☐ No ☐

What is the medical condition for which you have restrictions? _____

2. Are you presently treating with a doctor, chiropractor, psychiatrist, psychologist or other health-care provider? Yes ☐ No ☐

Please list the medical condition being treated: _____

Doctor's Name: _____ Specialty: _____

Doctor's Address: _____

3. If you are currently taking prescription medication other than those listed on the Explanation Page, please complete the requested information below.

Medication: _____ Prescribing Doctor: _____

Medication: _____ Prescribing Doctor: _____

4. Have you ever had an on the job accident? Yes ☐ No ☐

If you answered "YES," please provide the date for each injury and the nature of the injury:

How long were you on compensation? _____

Name of Employer: _____

5. Has a doctor recommended a surgical procedure, which has not been completed prior to this date, including but not limited to knee, hip or shoulder replacement? Yes ☐ No ☐

If you answered YES, please provide:

Recommended surgery: _____

Approximate date of recommendation: _____

Doctor's Name: _____ Specialty: _____

Doctor's Address: _____

X Employee Signature: _____ Date: _____

Employer Representative: _____ Date: _____

TO BE COMPLETED BY EMPLOYEE

EMPLOYEE WARNING

FAILURE TO ANSWER TRUTHFULLY AND/OR CORRECTLY TO ANY OF THE QUESTIONS ON THIS FORM MAY RESULT IN A FORFEITURE OF ANY AND ALL WORKERS COMPENSATION BENEFITS UNDER La. R.S. 23:1208.1.

I have completed this form honestly and to the best of my knowledge. I understand that providing false information or omitting pertinent information could result in loss of my workers compensation benefits should I become injured on the job.

* Employee Signature: _____ Date: _____

* Employee Printed Name: _____

TO BE COMPLETED BY EMPLOYER REPRESENTATIVE

EMPLOYER WARNING

PURSUANT TO La. R.S. 23:1208 OF THE LOUISIANA WORKERS' COMPENSATION ACT, IT SHALL BE UNLAWFUL FOR A PERSON, FOR THE PURPOSE OF OBTAINING OR DEFEATING ANY BENEFIT PAYMENT UNDER THE PROVISIONS OF THIS CHAPTER, EITHER FOR HIMSELF OR FOR ANY OTHER PERSON, TO WILLFULLY MAKE A FALSE STATEMENT OR REPRESENTATION. PENALTIES FOR VIOLATIONS INCLUDE IMPRISONMENT, FINES, AND/OR THE FORFEITURE OF BENEFITS.

You must certify the following:

1. That I am an authorized representative of the employer designated to obtain and review the information provided by the employee on this questionnaire;
2. That I have provided the employee with as many copies of the Explanation Page as needed and have confirmed the number of and labeled the pages of this questionnaire;
3. That I have provided assistance to the employee (if requested) in responding to the questions on this questionnaire;
4. That the information sought by this authorization is made on an applicant for employment only after a conditional job offer has been made and accepted, or on a current employee; and
5. That the information obtained in the authorization will **NOT** be used to discriminate in any manner against the individual who is the subject of this authorization on any basis, in violation of the Americans with Disabilities Act of 1990, 42 U.S.C. §12101, *et seq.*, or any other state or federal law;
6. That if requested, a photocopy of this fully completed and signed form will be provided to the employee.

Employer Representative Signature: _____ Date: _____

Employer Representative Printed Name: Morgan Fitch

Title: Admin. Assist. Personnel Dept.

STATE OF LOUISIANA
DEPARTMENT OF CHILDREN AND FAMILY SERVICES
CHILD ABUSE AND NEGLECT REQUEST AND CONSENT FORM B

This form must be completed by any person who is requesting a Child Abuse and Neglect Clearance, and signed by the applicant. This form must be signed by the requestor, who will receive the results of the child abuse and neglect clearance. Completing the optional identifying information fields on the form will assist in conducting an accurate search.

This consent form shall be used for Licensed Out of State Child Care Facilities; Louisiana DCFS Licensed Facilities; Louisiana Department of Health Licensed Therapeutic Group Homes; Out of State Licensed Residential Facilities that house foster children or meet the federal definition of a child care institution; In State Licensed Office of Juvenile Justice Detention Center employees; In State School Administrators, Teachers, or Other School Employees; and Owners, Operators, or participants in the governance of an In State DCFS Licensed residential facility.

Note: Licensed Early Learning Centers located on school campuses must utilize the background clearance process through LDOE

I. Employer's Identifying Information:

*Name of Employer, Agency, or Facility (Print or Type) Ouachita Parish School Board		*Entity Type ☐ Out of State Child Care Facilities ☐ Louisiana DCFS Licensed Facilities ☐ Louisiana Department of Health Licensed Therapeutic Group Homes ☐ Out of State Licensed Residential Facilities that house foster children or meet the federal definition of a child care institution ☐ In State Licensed Office of Juvenile Justice Detention Center employees ☒ In State School Administrators, Teachers, or Other School Employees ☐ Owners, Operators, or participants in the governance of an In State DCFS Licensed residential facility	
*Physical Address 1600 North 7 th Street	*City West Monroe	*State LA	*Zip 71291
*Mailing Address 1600 North 7 th Street	*City West Monroe	*State LA	*Zip 71291
*Work Phone # (one main contact number is mandatory) (318)432-5206	*Home Phone #		*Alternate Phone # (318)432-5206
Provider # (If Applicable)	Agency License # (If applicable)	EIN # (If Applicable) FEIN 726001066	

II. Applicant's Information:

*Last Name	*First Name	*Middle Name	
*Aliases, Maiden Name, Previous Married Name(s):			
*Date of Birth:	*Place of Birth (city)	*Place of Birth (state)	*Social Security #
*Race: ☐ White ☐ Black/African-American ☐ American Indian/Alaskan Native ☐ Asian ☐ Native Hawaiian/other Pacific Islander ☐ Other	*(Circle)	Male	Female
*Home Phone # (one main contact number is mandatory)	*Cell Phone	*Work Phone #	*Alternate Phone #
*Current Physical Address	*City	*State	*Zip
*Mailing Address	*City	*State	*Zip
*Email Address:			
*Identification Type ☐ State Issued Driving License ☐ State Issued Identification	*Identification (ID) #	*State Issued By	*ID Expiration Date
*Marital Status	Spouse (name) (if married)		Spouse (DOB) (if married)
Previous Spouse (name)	Previous Spouse (DOB)		
Previous Spouse (name)	Previous Spouse (DOB)		

*List previous addresses for the past 5 years:

*Physical Address	*City	*State	*Zip	*From MM__ YR__ *To MM__ YR__
Physical Address	City	State	Zip	From MM__ YR__ To MM__ YR__
Physical Address	City	State	Zip	From MM__ YR__ To MM__ YR__
Physical Address	City	State	Zip	From MM__ YR__ To MM__ YR__
Physical Address	City	State	Zip	From MM__ YR__ To MM__ YR__

List children that the applicant has been responsible for: (*This information will only be used to confirm the accuracy of applicant's agency history)

First Name	Last Name	Date of Birth	Gender	Race

III. Applicant's Consent

The information given is true and complete to the best of my knowledge. I understand that in signing this form I give permission for DCFS to conduct a clearance of the State Central Registry which contains information with regards to reports of certain valid/substantiated cases of child abuse and neglect, and release the results to the requestor noted above and licensing agency. Furthermore, this consent shall terminate a year from the date of my signature below. I also understand that I may be contacted by DCFS for additional information needed to finalize the clearance. I understand that the information I provide about myself shall be used solely for the purpose of conducting the State Central Registry check. I consent for DCFS to conduct a clearance of the state central registry and release all valid/ substantiated information to the requestor below for a determination to be made.

Signature of Applicant _____ **Date** _____

IV. Requestors Agreement

I acknowledge that any information received from the Department of Children and Family Services regarding the individual's inclusion in the State Central Registry is confidential and that this information cannot be shared with anyone unless otherwise allowed by State or Federal Laws/Regulations. All applicable federal and state laws and regulations shall apply including but not limited to Louisiana Revised Statute 46:56, which includes criminal penalties for the sharing of confidential information. I hereby certify that I am requesting a check of the State Central Registry, with the written consent of the individual. I understand that the State Central Registry clearance results for school employees, along with owners, operators and participants in the governance of an In-State DCFS Licensed residential facility only include investigations that began on or after 8/1/18.

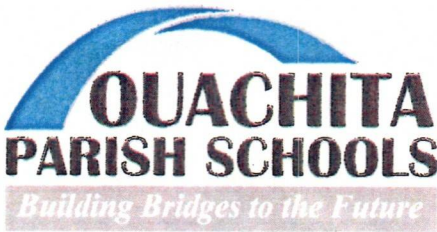
Printed Name of Requestor: _____

Signature of Requestor: _____ **Date:** _____

If this clearance is being submitted for employment purposes, by a Licensed Out of State Child Care Facility, Louisiana DCFS Licensed Facility, Louisiana DCFS Licensed Therapeutic Group Homes, Out of State Licensed Residential Facilities that house foster children or meet the federal definition of a child care institution and In State Licensed Office of Juvenile

Justice Detention Center employees the employee's state issued driving license or state issued identification, along with a \$25.00 payment for the clearance must be submitted, in order for the clearance to be processed. For other clearance types a \$25.00 payment will not be charged, however the employee's state issued driving license or state issued identification, must be submitted.

Example of
how pay works.
our cut off day is
a month before
pay day.



1600 North 7th Street • West Monroe, Louisiana 71291 • Phone: (318) 432-5000 • www.opsb.net

2026-2027

Paydays and Cut-Off Dates

Cut-Off

Payday

Monday, June 29, 2026

Thursday, July 23, 2026

Wednesday, July 22, 2026

Wednesday, August 26, 2026

example
Wednesday, August 19, 2026
any day worked between

Thursday, September 24, 2026

Wednesday, September 16, 2026

Monday, October 26, 2026 - will be paid on this day

Wednesday, October 21, 2026

Thursday, November 19, 2026

Wednesday, November 18, 2026

Thursday, December 17, 2026

Wednesday, December 16, 2026

Tuesday, January 26, 2027

Wednesday, January 20, 2027

Thursday, February 25, 2027

Wednesday, February 17, 2027

Thursday, March 25, 2027

Wednesday, March 17, 2027

Monday, April 26, 2027

Wednesday, April 21, 2027

Friday, May 21, 2027

Wednesday, May 19, 2027

Thursday, June 24, 2027