Ouachita Parish School Board
1600 N. 7th St
West Monroe, La 71291
318-432-5000 www.opsb.net

OUACHITA PARISH SCHOOLS
Building Bridges to the Future

Personnel Department
Phone: 318-432-5230
Fax: 318-432-5222

Cafeteria Sub Packet

Please read this page and the next before completing application and registering for your background check

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
- 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 and paperwork filled out 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 $57.50. To be fingerprinted please follow the directions below in order as written.
  - Call Morgan Futch for an appointment.
  - Go to opsb.net, jobs, support staff folder, fingerprint information and read steps 1 – 6 to register for your background check. (the next page is the direction for the fingerprints)
  - Bring a debt or credit card only to pay for 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

CAFETERIA BACKGROUND CHECK INFORMATION

Fingerprint Payment Method: **it is best to do this on a computer or laptop**
Go to:
Opsb.net
Jobs
Cafeteria
Support Staff Fingerprint Information

PLEASE READ ALL 6 STEPS BEFORE YOU BEGIN FILLING OUT REGISTRATION. You must have an appointment before you can register for a background check

Step 1: Click on the Identigo Link.

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 3: 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 your ID and debit card or credit card to pay for your background check. The cost is $57.50

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.

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

OUACHITA PARISH SCHOOLS
Building Bridges to the Future

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

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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 Bard 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

R-1300 (1/26)

LOUISIANA DEPARTMENT of REVENUE

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

Form **W-4**

Department of the Treasury
Internal Revenue Service

Employee's Withholding Certificate

Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay.
Give Form W-4 to your employer.
Your withholding is subject to review by the IRS.

OMB No. 1545-0074

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 *Exemption from withholding* on page 2. I understand I will need to submit a new Form W-4 for 2027 . ☐

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)

Employment Eligibility Verification

Department of Homeland Security

U.S. Citizenship and Immigration Services

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

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

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

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

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

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

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

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

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

- ☐ 1. A citizen of the United States
- ☐ 2. A noncitizen national of the United States (See Instructions.)
- ☐ 3. A lawful permanent resident (Enter USCIS or A-Number.)
- ☐ 4. An alien authorized to work until (exp. date, if any) _____

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

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

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

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

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

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

Additional Information

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

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

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

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

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

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

Jason Thompson – Chief of Staff
jasonthompson@opsb.net

OUACHITA PARISH SCHOOLS
Building Bridges to the Future

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

SEXUAL MISCONDUCT DISCLOSURE STATEMENT

As required by Louisiana Revised Statue 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**

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: DPSB

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: _____

X 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.

X Employee Signature: _____ Date: _____

X 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: Morgan Futon Date: _____

Employer Representative Printed Name: Morgan Futon

Title: Admin Assist Personnel

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**

OUACHITA PARISH SCHOOLS
Building Bridges to the Future

OUACHTA 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

OUACHITA PARISH SCHOOLS

Building Bridges to the Future

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

Revised 3/3/2025

OUACHITA PARISH SCHOOLS

Building Bridges to the Future

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 either 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 student. 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**

_____

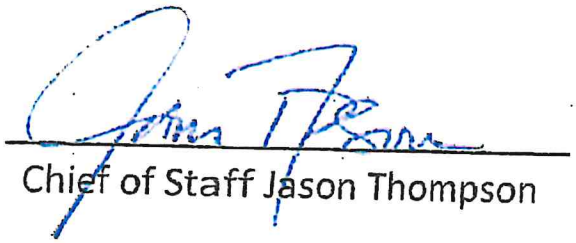
Date

Mandatory 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

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

OUACHITA PARISH SCHOOLS
Building Bridges to the Future

OBRA/PST Acknowledgement

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 OBRA/PST investment programs. The School Board does not contribute to the OBRA/PST 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 page in this packet is the form for the OBRA/PST Program. Please complete the sections with the asterisks.

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

_____ _____

Signature **Printed Name**

_____

Date

OBRA/PST Acknowledgement Card
(Please complete and submit to your Payroll Center)

Plan Information

Employer Name: OPSB
Employer Plan Number: 018173
Employer's Phone Number: 318-432-5000

Deferral Amount*	Payroll Frequency
%	monthly

*Contributions to the OBRA Plan must be a minimum of 7.5% of compensation.

Allocation: 100% Nationwide Fixed Account

Participant Information

Name:	
Mailing Address:	
City, State, & Zip Code:	
SS#:	Date of Birth:
Contact Phone:	Gender (check one): ☐ M ☐ F
Email:	

Beneficiary Information

*If there are additional beneficiaries, please attach a separate sheet.

Primary Beneficiary	
Name:	
Address:	
City, State, & Zip Code:	
SSN:	Date of Birth:
Relationship:	

Contingent Beneficiary	
Name:	
Address:	
City, State, & Zip Code:	
SSN:	Date of Birth:
Relationship:	

I acknowledge and understand that my participation in the plan is governed by the Plan Document and the Informational Sheet. I understand that 100% of my deferrals will be deposited in the Nationwide Fixed Account held with Nationwide Life Insurance Company.

Participant Signature	Date	Retirement Specialist	Agent #
		Megan Wyatt	

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)	*Entity Type
Ouachita Parish School Board	○ 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	*City	*State	*Zip
1600 North 7th Street	West Monroe	LA	71291
*Mailing Address	*City	*State	*Zip
1600 North 7th Street	West Monroe	LA	71291

*Work Phone # (one main contact number is mandatory)	*Home Phone #	*Alternate Phone #
(318)432-5206		(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: Kim Arthurs

Signature of Requestor: Kim Arthurs 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.

OUACHITA PARISH SCHOOLS
Building Bridges to the Future
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
Wednesday, August 19, 2026	Thursday, September 24, 2026
Wednesday, September 16, 2026	Monday, October 26, 2026
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

example

any day worked between

will be paid on this da