

New Hire Forms

EMPLOYEE ACKNOWLEDGEMENT

Section 1 - Documents for employees to complete and for you to retain in their personnel file.

- % Employee Acknowledgement Form
- % Employee Information Sheet
- % W-4 Form - for Federal Tax Withholding
- % I-9 Form - for Immigration Compliance
- % Notice to Employee : Wage Theft Prevention Act Notice (CA Hourly Employees Only)
- % Workers' Compensation Pre-Designation Form, if applicable
- % At-Will Acknowledgement
- % Meal and Rest Period Acknowledgement
- % Unlawful Harassment Acknowledgement and Policy

Section 2 - The following brochures are to be retained by the employee for their records.

- % Sexual Harassment – The Facts About Sexual Harassment
- % Paid Family Leave Information (DE 2511)
- % Disability Insurance Provisions (DE 2515)
- % Earned Income Tax Credit Notice
- % WC - Time of Hire Pamphlet

Please sign below indicating that you have received all the items listed above. A copy of this acknowledgement will be retained in your personnel file.

Employee's Signature

Date

Employee's Name (Printed)

Company Name

EMPLOYEE INFORMATION SHEET

Employee Information (To be completed by employee)	Employee Name: First Name: Last Name: Middle Initial: Nick Name:			
	Gender ☐ M ☐ F	Date of Birth (MM/DD/YY) / /		Social Security Number - -
	Present Address			Home Phone Number () -
	City	State	Zip Code	Alternative Phone Number () -
	Alternate/W2 Address (If different from above)			Fax Number () -
	City	State	Zip Code	E-Mail
	Race (Optional Information): Any information relating to race/ethnic origin, gender and job category is collected in order to demonstrate compliance with Federal, State and local regulations. The information is not used in the evaluation of the employee. Veteran? ☐ Yes ☐ No ☐ White (Not of Hispanic Origin) ☐ Hispanic ☐ N/A Two or More Races (Non Hispanic or Latino) ☐ Black (Not of Hispanic Origin) ☐ Asian or Pacific Islander ☐ American Indian or Alaska Native			
	Emergency Contact: First Name: Last Name:			
	Relationship			Phone Number () -
Employment Information (To be completed by Supervisor)	Employee's Signature			Date
	Hire Date:		Job Title:	
	Pay Type: ☐ Full Time ☐ Part Time ☐ Temporary ☐ On-call		Pay Rate: ☐ Hourly \$ _____ ☐ Salary \$ _____	
		Supervisor Signature: Date:		

Form W-4 (2017)

Purpose. Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay. Consider completing a new Form W-4 each year and when your personal or financial situation changes.

Exemption from withholding. If you are exempt, complete **only** lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2017 expires February 15, 2018. See Pub. 505, Tax Withholding and Estimated Tax.

Note: If another person can claim you as a dependent on his or her tax return, you can't claim exemption from withholding if your total income exceeds \$1,050 and includes more than \$350 of unearned income (for example, interest and dividends).

Exceptions. An employee may be able to claim exemption from withholding even if the employee is a dependent, if the employee:

- Is age 65 or older,
- Is blind, or
- Will claim adjustments to income; tax credits; or itemized deductions, on his or her tax return.

The exceptions don't apply to supplemental wages greater than \$1,000,000.

Basic instructions. If you aren't exempt, complete the **Personal Allowances Worksheet** below. The worksheets on page 2 further adjust your withholding allowances based on itemized deductions, certain credits, adjustments to income, or two-earners/multiple jobs situations.

Complete all worksheets that apply. However, you may claim fewer (or zero) allowances. For regular wages, withholding must be based on allowances you claimed and may not be a flat amount or percentage of wages.

Head of household. Generally, you can claim head of household filing status on your tax return only if you are unmarried and pay more than 50% of the costs of keeping up a home for yourself and your dependent(s) or other qualifying individuals. See Pub. 501, Exemptions, Standard Deduction, and Filing Information, for information.

Tax credits. You can take projected tax credits into account in figuring your allowable number of withholding allowances. Credits for child or dependent care expenses and the child tax credit may be claimed using the **Personal Allowances Worksheet** below. See Pub. 505 for information on converting your other credits into withholding allowances.

Nonwage income. If you have a large amount of nonwage income, such as interest or dividends, consider making estimated tax payments using Form 1040-ES, Estimated Tax for Individuals. Otherwise, you may owe additional tax. If you have pension or annuity income, see Pub. 505 to find out if you should adjust your withholding on Form W-4 or W-4P.

Two earners or multiple jobs. If you have a working spouse or more than one job, figure the total number of allowances you are entitled to claim on all jobs using worksheets from only one Form W-4. Your withholding usually will be most accurate when all allowances are claimed on the Form W-4 for the highest paying job and zero allowances are claimed on the others. See Pub. 505 for details.

Nonresident alien. If you are a nonresident alien, see Notice 1392, Supplemental Form W-4 Instructions for Nonresident Aliens, before completing this form.

Check your withholding. After your Form W-4 takes effect, use Pub. 505 to see how the amount you are having withheld compares to your projected total tax for 2017. See Pub. 505, especially if your earnings exceed \$130,000 (Single) or \$180,000 (Married).

Future developments. Information about any future developments affecting Form W-4 (such as legislation enacted after we release it) will be posted at www.irs.gov/w4.

Personal Allowances Worksheet (Keep for your records.)

A	Enter "1" for yourself if no one else can claim you as a dependent	A	_____				
B	Enter "1" if: <table><tr><td>• You're single and have only one job; or</td><td rowspan="3">}</td></tr><tr><td>• You're married, have only one job, and your spouse doesn't work; or</td></tr><tr><td>• Your wages from a second job or your spouse's wages (or the total of both) are \$1,500 or less.</td></tr></table>	• You're single and have only one job; or	}	• You're married, have only one job, and your spouse doesn't work; or	• Your wages from a second job or your spouse's wages (or the total of both) are \$1,500 or less.	B	_____
• You're single and have only one job; or	}						
• You're married, have only one job, and your spouse doesn't work; or							
• Your wages from a second job or your spouse's wages (or the total of both) are \$1,500 or less.							
C	Enter "1" for your spouse . But, you may choose to enter "-0-" if you are married and have either a working spouse or more than one job. (Entering "-0-" may help you avoid having too little tax withheld.)	C	_____				
D	Enter number of dependents (other than your spouse or yourself) you will claim on your tax return	D	_____				
E	Enter "1" if you will file as head of household on your tax return (see conditions under Head of household above)	E	_____				
F	Enter "1" if you have at least \$2,000 of child or dependent care expenses for which you plan to claim a credit	F	_____				
G	Child Tax Credit (including additional child tax credit). See Pub. 972, Child Tax Credit, for more information. • If your total income will be less than \$70,000 (\$100,000 if married), enter "2" for each eligible child; then less "1" if you have two to four eligible children or less "2" if you have five or more eligible children. • If your total income will be between \$70,000 and \$84,000 (\$100,000 and \$119,000 if married), enter "1" for each eligible child.	G	_____				
H	Add lines A through G and enter total here. (Note: This may be different from the number of exemptions you claim on your tax return.) ►	H	_____				
For accuracy, complete all worksheets that apply. <table><tr><td>• If you plan to itemize or claim adjustments to income and want to reduce your withholding, see the Deductions and Adjustments Worksheet on page 2.</td></tr><tr><td>• If you are single and have more than one job or are married and you and your spouse both work and the combined earnings from all jobs exceed \$50,000 (\$20,000 if married), see the Two-Earners/Multiple Jobs Worksheet on page 2 to avoid having too little tax withheld.</td></tr><tr><td>• If neither of the above situations applies, stop here and enter the number from line H on line 5 of Form W-4 below.</td></tr></table>		• If you plan to itemize or claim adjustments to income and want to reduce your withholding, see the Deductions and Adjustments Worksheet on page 2.	• If you are single and have more than one job or are married and you and your spouse both work and the combined earnings from all jobs exceed \$50,000 (\$20,000 if married), see the Two-Earners/Multiple Jobs Worksheet on page 2 to avoid having too little tax withheld.	• If neither of the above situations applies, stop here and enter the number from line H on line 5 of Form W-4 below.			
• If you plan to itemize or claim adjustments to income and want to reduce your withholding, see the Deductions and Adjustments Worksheet on page 2.							
• If you are single and have more than one job or are married and you and your spouse both work and the combined earnings from all jobs exceed \$50,000 (\$20,000 if married), see the Two-Earners/Multiple Jobs Worksheet on page 2 to avoid having too little tax withheld.							
• If neither of the above situations applies, stop here and enter the number from line H on line 5 of Form W-4 below.							

----- Separate here and give Form W-4 to your employer. Keep the top part for your records. -----

Form W-4 Department of the Treasury Internal Revenue Service		Employee's Withholding Allowance Certificate		OMB No. 1545-0074 2017	
1 Your first name and middle initial		Last name		2 Your social security number	
Home address (number and street or rural route)		3 ☐ Single ☐ Married ☐ Married, but withhold at higher Single rate. Note: If married, but legally separated, or spouse is a nonresident alien, check the "Single" box.			
City or town, state, and ZIP code		4 If your last name differs from that shown on your social security card, check here. You must call 1-800-772-1213 for a replacement card. ► ☐			
5 Total number of allowances you are claiming (from line H above or from the applicable worksheet on page 2)		5			
6 Additional amount, if any, you want withheld from each paycheck		6		\$	
7 I claim exemption from withholding for 2017, and I certify that I meet both of the following conditions for exemption. • Last year I had a right to a refund of all federal income tax withheld because I had no tax liability, and • This year I expect a refund of all federal income tax withheld because I expect to have no tax liability. If you meet both conditions, write "Exempt" here		7			
Under penalties of perjury, I declare that I have examined this certificate and, to the best of my knowledge and belief, it is true, correct, and complete.					
Employee's signature (This form is not valid unless you sign it.) ►					
8 Employer's name and address (Employer: Complete lines 8 and 10 only if sending to the IRS.)		9 Office code (optional)		10 Employer identification number (EIN)	

Deductions and Adjustments Worksheet**Note:** Use this worksheet *only* if you plan to itemize deductions or claim certain credits or adjustments to income.

1	Enter an estimate of your 2017 itemized deductions. These include qualifying home mortgage interest, charitable contributions, state and local taxes, medical expenses in excess of 10% of your income, and miscellaneous deductions. For 2017, you may have to reduce your itemized deductions if your income is over \$313,800 and you're married filing jointly or you're a qualifying widow(er); \$287,650 if you're head of household; \$261,500 if you're single, not head of household and not a qualifying widow(er); or \$156,900 if you're married filing separately. See Pub. 505 for details	1	\$	_____
2	Enter: $\left\{ \begin{array}{l} \$12,700 \text{ if married filing jointly or qualifying widow(er)} \\ \$9,350 \text{ if head of household} \\ \$6,350 \text{ if single or married filing separately} \end{array} \right\}$	2	\$	_____
3	Subtract line 2 from line 1. If zero or less, enter "-0-"	3	\$	_____
4	Enter an estimate of your 2017 adjustments to income and any additional standard deduction (see Pub. 505)	4	\$	_____
5	Add lines 3 and 4 and enter the total. (Include any amount for credits from the <i>Converting Credits to Withholding Allowances for 2017 Form W-4</i> worksheet in Pub. 505.)	5	\$	_____
6	Enter an estimate of your 2017 nonwage income (such as dividends or interest)	6	\$	_____
7	Subtract line 6 from line 5. If zero or less, enter "-0-"	7	\$	_____
8	Divide the amount on line 7 by \$4,050 and enter the result here. Drop any fraction	8		_____
9	Enter the number from the Personal Allowances Worksheet , line H, page 1	9		_____
10	Add lines 8 and 9 and enter the total here. If you plan to use the Two-Earners/Multiple Jobs Worksheet , also enter this total on line 1 below. Otherwise, stop here and enter this total on Form W-4, line 5, page 1	10		_____

Two-Earners/Multiple Jobs Worksheet (See *Two earners or multiple jobs* on page 1.)**Note:** Use this worksheet *only* if the instructions under line H on page 1 direct you here.

1	Enter the number from line H, page 1 (or from line 10 above if you used the Deductions and Adjustments Worksheet)	1	_____
2	Find the number in Table 1 below that applies to the LOWEST paying job and enter it here. However , if you are married filing jointly and wages from the highest paying job are \$65,000 or less, do not enter more than "3"	2	_____
3	If line 1 is more than or equal to line 2, subtract line 2 from line 1. Enter the result here (if zero, enter "-0-") and on Form W-4, line 5, page 1. Do not use the rest of this worksheet	3	_____

Note: If line 1 is **less than** line 2, enter "-0-" on Form W-4, line 5, page 1. Complete lines 4 through 9 below to figure the additional withholding amount necessary to avoid a year-end tax bill.

4	Enter the number from line 2 of this worksheet	4	_____
5	Enter the number from line 1 of this worksheet	5	_____
6	Subtract line 5 from line 4	6	_____
7	Find the amount in Table 2 below that applies to the HIGHEST paying job and enter it here	7	\$ _____
8	Multiply line 7 by line 6 and enter the result here. This is the additional annual withholding needed	8	\$ _____
9	Divide line 8 by the number of pay periods remaining in 2017. For example, divide by 25 if you are paid every two weeks and you complete this form on a date in January when there are 25 pay periods remaining in 2017. Enter the result here and on Form W-4, line 6, page 1. This is the additional amount to be withheld from each paycheck	9	\$ _____

Table 1**Table 2**

Married Filing Jointly		All Others		Married Filing Jointly		All Others	
If wages from LOWEST paying job are—	Enter on line 2 above	If wages from LOWEST paying job are—	Enter on line 2 above	If wages from HIGHEST paying job are—	Enter on line 7 above	If wages from HIGHEST paying job are—	Enter on line 7 above
\$0 - \$7,000	0	\$0 - \$8,000	0	\$0 - \$75,000	\$610	\$0 - \$38,000	\$610
7,001 - 14,000	1	8,001 - 16,000	1	75,001 - 135,000	1,010	38,001 - 85,000	1,010
14,001 - 22,000	2	16,001 - 26,000	2	135,001 - 205,000	1,130	85,001 - 185,000	1,130
22,001 - 27,000	3	26,001 - 34,000	3	205,001 - 360,000	1,340	185,001 - 400,000	1,340
27,001 - 35,000	4	34,001 - 44,000	4	360,001 - 405,000	1,420	400,001 and over	1,600
35,001 - 44,000	5	44,001 - 70,000	5	405,001 and over	1,600		
44,001 - 55,000	6	70,001 - 85,000	6				
55,001 - 65,000	7	85,001 - 110,000	7				
65,001 - 75,000	8	110,001 - 125,000	8				
75,001 - 80,000	9	125,001 - 140,000	9				
80,001 - 95,000	10	140,001 and over	10				
95,001 - 115,000	11						
115,001 - 130,000	12						
130,001 - 140,000	13						
140,001 - 150,000	14						
150,001 and over	15						

Privacy Act and Paperwork Reduction Act Notice. We ask for the information on this form to carry out the Internal Revenue laws of the United States. Internal Revenue Code sections 3402(f)(2) and 6109 and their regulations require you to provide this information; your employer uses it to determine your federal income tax withholding. Failure to provide a properly completed form will result in your being treated as a single person who claims no withholding allowances; providing fraudulent information may subject you to penalties. Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation; to cities, states, the District of Columbia, and U.S. commonwealths and possessions for use in administering their tax laws; and to the Department of Health and Human Services for use in the National Directory of New Hires. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

You are not required to provide the information requested on a form that is subject to the Paperwork Reduction Act unless the form displays a valid OMB control number. Books or records relating to a form or its instructions must be retained as long as their contents may become material in the administration of any Internal Revenue law. Generally, tax returns and return information are confidential, as required by Code section 6103.

The average time and expenses required to complete and file this form will vary depending on individual circumstances. For estimated averages, see the instructions for your income tax return.

If you have suggestions for making this form simpler, we would be happy to hear from you. See the instructions for your income tax return.



Employment Eligibility Verification
Department of Homeland Security
U.S. Citizenship and Immigration Services

USCIS
Form I-9
OMB No. 1615-0047
Expires 08/31/2019

► **START HERE:** Read instructions carefully before completing this form. The instructions must be available, either in paper or electronically, during completion of this form. Employers are liable for errors in the completion of this form.

ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers **CANNOT** specify which document(s) an employee may present to establish employment authorization and identity. The refusal to hire or continue to employ an individual because the documentation presented has a future expiration date may also constitute illegal discrimination.

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	Other Last Names Used (if any)	
Address (Street Number and Name)			Apt. Number	City or Town		State ZIP Code
Date of Birth (mm/dd/yyyy)	U.S. Social Security Number [][][] - [][] - [][][][]		Employee's E-mail Address		Employee's Telephone Number	

I am aware that federal law provides for imprisonment and/or fines for false statements or use of false documents in connection with the completion of this form.

I attest, under penalty of perjury, that I am (check one of the following boxes):

☐ 1. A citizen of the United States	
☐ 2. A noncitizen national of the United States (<i>See instructions</i>)	
☐ 3. A lawful permanent resident (Alien Registration Number/USCIS Number): _____	
☐ 4. An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy): _____ Some aliens may write "N/A" in the expiration date field. (<i>See instructions</i>)	
<i>Aliens authorized to work must provide only one of the following document numbers to complete Form I-9: An Alien Registration Number/USCIS Number OR Form I-94 Admission Number OR Foreign Passport Number.</i>	
1. Alien Registration Number/USCIS Number: _____ OR 2. Form I-94 Admission Number: _____ OR 3. Foreign Passport Number: _____ Country of Issuance: _____	
QR Code - Section 1 Do Not Write In This Space	

Signature of Employee	Today's Date (mm/dd/yyyy)
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Preparer and/or Translator Certification (check one):

☐ I did not use a preparer or translator. ☐ A preparer(s) and/or translator(s) assisted the employee in completing Section 1.
(Fields below must be completed and signed when preparers and/or translators assist an employee in completing Section 1.)

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

Signature of Preparer or Translator		Today's Date (mm/dd/yyyy)	
Last Name (Family Name)		First Name (Given Name)	
Address (Street Number and Name)		City or Town	State ZIP Code



Employer Completes Next Page





Employment Eligibility Verification
Department of Homeland Security
U.S. Citizenship and Immigration Services

USCIS
Form I-9
OMB No. 1615-0047
Expires 08/31/2019

Section 2. Employer or Authorized Representative Review and Verification

(Employers or their authorized representative must complete and sign Section 2 within 3 business days of the employee's first day of employment. You must physically examine one document from List A OR a combination of one document from List B and one document from List C as listed on the "Lists of Acceptable Documents.")

Employee Info from Section 1	Last Name (Family Name)	First Name (Given Name)	M.I.	Citizenship/Immigration Status
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List A Identity and Employment Authorization	OR	List B Identity	AND	List C Employment Authorization
Document Title		Document Title		Document Title
Issuing Authority		Issuing Authority		Issuing Authority
Document Number		Document Number		Document Number
Expiration Date (if any)(mm/dd/yyyy)		Expiration Date (if any)(mm/dd/yyyy)		Expiration Date (if any)(mm/dd/yyyy)
Document Title		Additional Information QR Code - Sections 2 & 3 Do Not Write In This Space		
Issuing Authority				
Document Number				
Expiration Date (if any)(mm/dd/yyyy)				
Document Title				
Issuing Authority				
Document Number				
Expiration Date (if any)(mm/dd/yyyy)				

Certification: I attest, under penalty of perjury, that (1) I have examined the document(s) presented by the above-named employee, (2) the above-listed document(s) appear 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.

The employee's first day of employment (mm/dd/yyyy): _____ (See instructions for exemptions)

Signature of Employer or Authorized Representative		Today's Date(mm/dd/yyyy)		Title of Employer or Authorized Representative	
Last Name of Employer or Authorized Representative		First Name of Employer or Authorized Representative		Employer's Business or Organization Name	
Employer's Business or Organization Address (Street Number and Name)			City or Town		State ZIP Code

Section 3. Reverification and Rehires (To be completed and signed by employer or authorized representative.)

A. New Name (if applicable)			B. Date of Rehire (if applicable)	
Last Name (Family Name)		First Name (Given Name)	Middle Initial	Date (mm/dd/yyyy)

C. If the employee's previous grant of employment authorization has expired, provide the information for the document or receipt that establishes continuing employment authorization in the space provided below.

Document Title	Document Number	Expiration Date (if any) (mm/dd/yyyy)
----------------	-----------------	---------------------------------------

I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented document(s), the document(s) I have examined appear to be genuine and to relate to the individual.

Signature of Employer or Authorized Representative	Today's Date (mm/dd/yyyy)	Name of Employer or Authorized Representative
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LISTS OF ACCEPTABLE DOCUMENTS

All documents must be UNEXPIRED

Employees may present one selection from List A
or a combination of one selection from List B and one selection from List C.

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

Examples of many of these documents appear in Part 8 of the Handbook for Employers (M-274).

Refer to the instructions for more information about acceptable receipts.

NOTICE TO EMPLOYEE
Labor Code section 2810.5

EMPLOYEE

Employee Name: _____

Start Date: _____

EMPLOYER

Legal Name of Hiring Employer: _____

Is hiring employer a staffing agency/business (e.g., Temporary Services Agency; Employee Leasing Company; or Professional Employer Organization [PEO])? ☐ Yes ☐ No

Other Names Hiring Employer is "doing business as" (if applicable):

Physical Address of Hiring Employer's Main Office:

Hiring Employer's Mailing Address (if different than above):

Hiring Employer's Telephone Number: _____

If the hiring employer is a staffing agency/business (above box checked "Yes"), the following is the other entity for whom this employee will perform work:

Name: _____

Physical Address of Main Office: _____

Mailing Address: _____

Telephone Number: _____

WAGE INFORMATION

Rate(s) of Pay: _____ Overtime Rate(s) of Pay: _____

Rate by (check box): ☐ Hour ☐ Shift ☐ Day ☐ Week ☐ Salary ☐ Piece rate ☐ Commission

☐ Other (provide specifics): _____

Does a written agreement exist providing the rate(s) of pay? (check box) ☐ Yes ☐ No

If yes, are all rate(s) of pay and bases thereof contained in that written agreement? ☐ Yes ☐ No

Allowances, if any, claimed as part of minimum wage (including meal or lodging allowances):

(If the employee has signed the acknowledgment of receipt below, it does not constitute a "voluntary written agreement" as required under the law between the employer and employee in order to credit any meals or lodging against the minimum wage. Any such voluntary written agreement must be evidenced by a separate document.)

Regular Payday: _____

WORKERS' COMPENSATION

Insurance Carrier's Name: _____
Address: _____
Telephone Number: _____
Policy No.: _____
☐ Self-Insured (Labor Code 3700) and Certificate Number for Consent to Self-Insure: _____

PAID SICK LEAVE

Unless exempt, the employee identified on this notice is entitled to minimum requirements for paid sick leave under state law which provides that an employee:

- a. May accrue paid sick leave and may request and use up to 3 days or 24 hours of accrued paid sick leave per year;
- b. May not be terminated or retaliated against for using or requesting the use of accrued paid sick leave; and
- c. Has the right to file a complaint against an employer who retaliates or discriminates against an employee for
 1. requesting or using accrued sick days;
 2. attempting to exercise the right to use accrued paid sick days;
 3. filing a complaint or alleging a violation of Article 1.5 section 245 et seq. of the California Labor Code;
 4. cooperating in an investigation or prosecution of an alleged violation of this Article or opposing any policy or practice or act that is prohibited by Article 1.5 section 245 et seq. of the California Labor Code.

The following applies to the employee identified on this notice: *(Check one box)*

- ☐ 1. Accrues paid sick leave only pursuant to the minimum requirements stated in Labor Code §245 et seq. with no other employer policy providing additional or different terms for accrual and use of paid sick leave.
- ☐ 2. Accrues paid sick leave pursuant to the employer's policy which satisfies or exceeds the accrual, carryover, and use requirements of Labor Code §246.
- ☐ 3. Employer provides no less than 24 hours (or 3 days) of paid sick leave at the beginning of each 12-month period.
- ☐ 4. The employee is exempt from paid sick leave protection by Labor Code §245.5. (State exemption and specific subsection for exemption): _____

ACKNOWLEDGEMENT OF RECEIPT

(Optional)

(PRINT NAME of Employer representative)

(PRINT NAME of Employee)

(SIGNATURE of Employer Representative)

(SIGNATURE of Employee)

(Date)

(Date)

The employee's signature on this notice merely constitutes acknowledgement of receipt.

Labor Code section 2810.5(b) requires that the employer notify you in writing of any changes to the information set forth in this Notice within seven calendar days after the time of the changes, unless one of the following applies: (a) All changes are reflected on a timely wage statement furnished in accordance with Labor Code section 226; (b) Notice of all changes is provided in another writing required by law within seven days of the changes.

PREDESIGNATION OF PERSONAL PHYSICIAN

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

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

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

NOTICE OF PREDESIGNATION OF PERSONAL PHYSICIAN

Employee: Complete this section.

To: _____ (name of employer) If I have a work-related injury or illness, I choose to be treated by:

(name of doctor)(M.D., D.O., or medical group)

(street address, city, state, ZIP)

(telephone number)

Employee Name (please print):

Employee's Address:

Name of Insurance Company, Plan, or Fund providing health coverage for nonoccupational injuries or illnesses:

Employee's Signature _____ Date: _____

Physician: I agree to this Predesignation:

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

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

Title 8, California Code of Regulations, section 9783.

AT-WILL ACKNOWLEDGEMENT AGREEMENT

I agree that my employment is “at-will” during and after completion of any introductory period that the Company may have; that is, either the Company or I may terminate the employment relationship at any time, with or without cause and without prior notice, corrective action or progressive discipline. No representative or employee of the Company, other than the President, has the authority to enter into a contrary agreement. Furthermore, the President can enter into a contrary agreement only if it is accomplished in a written agreement that is signed by both you and the President. This represents an integrated agreement with respect to the at-will nature of the employment relationship.

I agree as well that the statements in the above paragraph describe the complete agreement between the Company and me regarding the at-will nature of my employment and that this agreement supercedes and replaces all prior or contemporaneous agreements, comments, or representations on these topics. The provisions of this agreement will apply except where the at-will nature of employment conflicts with state law or Collective Bargaining Agreement provisions.

Print Name

Date

Employee Signature

MEAL AND REST PERIOD POLICY AND ACKNOWLEDGEMENT

MEAL AND REST PERIODS

It is company policy that all non-exempt, hourly employees be provided meal and rest periods as follows:

Meal Periods:

Number of Hours Worked Per Shift	Number of Meal Periods
5 hours or less	No meal period
More than 5 hours up to 6 hours	1 unpaid 30-min. meal period (may be waived in writing)
More than 6 hours up to 10 hours	1 unpaid 30-min. meal period
More than 10 hours up to 12 hours	2 unpaid 30-min. meal periods – (may not be combined, 2 nd meal period may be waived in writing)
More than 12 hours	2 unpaid 30-min. meal periods (may not be combined)

Note:

Employees should not work more than 5 consecutive hours without beginning a meal period.

You may take your meal period as scheduled unless requested not to do so by your supervisor. Depending on your specific company policy, you may receive additional time beyond the required 30 minutes for meal periods. Your Supervisor will notify you if this is the case.

If you do not take a meal period and you do not report this to your supervisor, the company will conclude, as permitted, that you voluntarily chose to forego your meal period that was provided to you.

Rest Periods:

Number of Hours Worked Per Shift	Number of Rest Periods
Less than 3 ½ hours	No rest period
3 ½ hours up to 6 hours	One, 10-min. rest period
6 hours up to 10 hours	Two, 10-min. rest periods
10 hours up to 14 hours	Three, 10-min. rest periods
14 hours up to 18 hours	Four, 10-min. rest periods

If you are entitled to two rest periods, one should be taken before the meal period and one should be taken after the meal period. They should not be combined with each other or with your meal period. Rest periods should be taken, as far as practical, in the middle of each work period. Depending on your specific company policy, you may receive additional time beyond the required 10 minutes for rest periods. Your Supervisor will notify you if this is the case.

If you do not take a rest period and you do not report this to your supervisor, the company will conclude, as permitted, that you voluntarily chose to forego your rest period.

I have read and understand the “Meal and Rest Period Policy” and agree to abide by it.

Print Name

Date

Employee Signature

POLICY AGAINST UNLAWFUL HARASSMENT

The Company is committed to providing a work environment free of harassment and discrimination. In keeping with this commitment, the Company maintains a strict policy prohibiting unlawful harassment of any kind, including sexual harassment and harassment based on race, religion, color, gender, national origin or ancestry, pregnancy, childbirth or related medical conditions, physical or mental disability, medical condition, marital status, age, sexual orientation, or any other basis protected by federal, state, or local law or ordinance or regulation. It also prohibits unlawful harassment based on the perception that anyone has any of those characteristics, or is associated with a person who has or is perceived as having any of those characteristics. All such harassment is unlawful. The Company's anti-harassment policy applies to all employer agents and employees, including supervisors and non-supervisory employees. It also extends to vendors, independent contractors, non-employees and others doing business with the Company.

Prohibited unlawful harassment includes, but is not limited to, the following behavior:

- Verbal conduct such as epithets, derogatory jokes or comments, slurs or unwanted sexual advances, invitations, or comments;
- Visual conduct such as derogatory and/or sexually-oriented posters, photography, cartoons, drawings, letters or gestures;
- Physical conduct including assault, unwanted touching, intentionally blocking normal movement or interfering with work because of sex, race, or any other protected basis;
- Threats and demands to submit to sexual requests as a condition of continued employment, or to avoid some other loss, and offers of employment benefits in return for sexual favors; and
- Retaliation for reporting or threatening to report unlawful harassment.

If you believe that you have been unlawfully harassed, you should promptly report the facts of the incident or incidents and the names of the individuals involved to your own or any other company supervisor, personnel administrator of the Company, as soon as possible after the incident. Your complaint should include details of the incident or incidents, names of any individual(s) involved, and names of any witnesses. Supervisors will refer all harassment complaints to the personnel administrator, or the President of the Company. The Company will immediately undertake an effective, thorough, and objective investigation of the harassment allegations.

If the Company determines that unlawful harassment has occurred, effective remedial action will be taken in accordance with the circumstances involved. Any employee determined by the Company to be responsible for unlawful harassment will be subject to appropriate disciplinary action, up to, and including termination. A company representative will advise all parties concerned of the results of the investigation. The Company will not retaliate against you for filing a complaint, or participating in an investigation, and will not tolerate or permit retaliation by management, employees or co-workers.

The Company encourages all employees to report any incidents of harassment forbidden by this policy immediately so that complaints can be quickly and fairly resolved. You also should be aware that your applicable state agency and/or the Federal Equal Employment Opportunity Commission investigate and prosecute complaints of prohibited harassment in employment. If you think you have been harassed or that you have been retaliated against for resisting or complaining, you may file a complaint with the appropriate agency. The nearest office is listed in the telephone book.

These behaviors are defined and described in a manner consistent with the law. When it comes to dealing with the subject of unlawful harassment, specifically sexual harassment, the following applies:

Quid pro quo harassment (Latin meaning "this for that") occurs when specific employment benefits (like a job offer, a raise, a comfortable office) are promised or withheld as a means of coercing sexual favors.

Hostile Environment harassment occurs when certain conduct unreasonably interferes with the victim's work performance or creates an intimidating, hostile, or offensive working environment.

In certain cases, sexual harassment can include gender-based harassment of a person of the same sex. Pursuant to the Company's commitment to ensure that unlawful harassment is not tolerated, it is everyone's responsibility to report all incidents of unlawful harassment to Management.

Even if the unlawful harassment is not directed at you, it is still your responsibility to report witnessed unlawful harassment.

Below are the procedures and responsibilities that the Company requires every employee to follow and adhere to:

POLICY AGAINST UNLAWFUL HARASSMENT

EMPLOYEE PROCEDURE AND RESPONSIBILITY:

All employees are to comply with this policy.

Any employee who believes that he or she is being unlawfully harassed should promptly take the following steps:

1. If comfortable, politely but firmly confront whoever is doing the harassing. State how you feel about his or her actions, and request that the person cease harassing you immediately.
2. If the harassment continues, or if you believe some employment consequences may result from your confrontation, you should promptly report the facts of the incident or incidents and the names of the individuals involved to your own or any other company supervisor, or personnel administrator of the Company, as soon as possible after the incident. If circumstances prohibit this response, you must report the behavior to Management.
3. If you believe inadequate action is being taken to resolve your complaint, communicate it directly to the President of the Company for resolution of your problem. The policy of this company is to listen to all corroboration, and quickly apply sanctions when appropriate.
4. Sanctions against unlawful harassment will depend upon the circumstances surrounding the incident. Minor first offenses may lead to written reprimands and/or time off without pay. Major or multiple offenses may lead to the dismissal of the offender.

If you have any questions in regards to this policy or any other Company policy, please see a Supervisor, or a member of Management.

SUPERVISOR PROCEDURE AND RESPONSIBILITY:

Every member of the Company's Supervision and Management staff is responsible for ensuring that no unlawful harassment of any kind occurs within his or her area of authority.

1. Any complaint of unlawful harassment should receive the immediate attention of the Supervisor whom it is made and should be reported immediately to Human Resources.
2. No Supervisor is to conduct any investigation of unlawful harassment without the consent and involvement of Management or Human Resources. Investigation of a complaint of harassment normally will include conferring with the parties and witnesses named by the complaining employee.
3. Because of the sensitive nature, complaints of harassment will be investigated with particular care and will remain, to the extent possible, strictly confidential.
4. In no event will information concerning a complaint of harassment be released by the company to third parties or to anyone within the company who is not involved with the investigation. More specifically, information will not be released to an affected employee's family, the news media, or a prospective employer seeking a reference. The purpose of this provision is to protect the confidentiality of the employee who files a complaint, to encourage the reporting of any incidents of unlawful harassment, and to protect the reputation of any employee wrongfully charged with harassment.
5. If the investigation reveals that the complaint is valid, prompt disciplinary action designed to stop the unlawful harassment immediately and to prevent its recurrence will be taken.
6. Management will ensure that the policy statement is distributed throughout the organization.

I acknowledge that I have read and received my employer's zero tolerance policy against unlawful harassment. I promise that I will fully comply with all aspects of that policy. I agree that I will not engage in any conduct that would constitute unlawful harassment of another individual. I also agree to comply with my obligations under the policy to report any unlawful harassment immediately in accordance with the company procedures. I understand that my employer will be unable to promptly investigate and remedy problems that may arise if I fail to cooperate fully and fulfill these essential commitments.

Print Name

Date

Employee Signature



The definition of sexual harassment includes many forms of offensive behavior.



Department of Fair Employment and Housing

such as a lead, supervisor, manager or agent;

- the employer had no knowledge of the harassment;
- there was a program to prevent harassment; and
- once aware of any harassment, the employer took immediate and appropriate corrective action to stop the harassment.

Filing a Complaint

Employees or job applicants who believe that they have been sexually harassed may file a complaint of discrimination with DFEH within **one year** of the harassment.

DFEH serves as a neutral fact-finder and attempts to help the parties voluntarily resolve disputes. If DFEH finds sufficient evidence to establish that discrimination occurred and settlement efforts fail, the Department may file a civil complaint in state or federal court on behalf of the complaining party. The DFEH may seek punitive damages is entitled to attorney's fees and costs if it prevails in litigation.

Remedies include:

- Fines or damages for emotional distress from each employer or person found to have violated the law
- Hiring or reinstatement
- Back pay or promotion
- Changes in the policies or practices of the involved employer

Employees can also pursue the matter through a private lawsuit in civil court after a complaint has been filed with DFEH and a Right-to-Sue Notice has been issued.

For more information, see publication DFEH-159 "Guide for Complainants and Respondents."

For more information, contact DFEH toll free at
(800) 884-1684
TTY number at **(800) 700-2320**
or visit our Web site at www.dfeh.ca.gov

In accordance with the California Government Code and ADA requirements, this publication can be made available in Braille, large print, computer disk, or tape cassette as a disability-related reasonable accommodation for an individual with a disability. To discuss how to receive a copy of this publication in an alternative format, please contact DFEH at the numbers above.



State of California
Department of Fair Employment & Housing

DFEH-185 (11/14)

Sexual Harassment

The Facts About Sexual Harassment

The *Fair Employment and Housing Act* (FEHA) defines sexual harassment as harassment based on sex or of a sexual nature; gender harassment; and harassment based on pregnancy, childbirth, or related medical conditions. The definition of sexual harassment includes many forms of offensive behavior, including harassment of a person of the same gender as the harasser. The following is a partial list of types of sexual harassment:

- Unwanted sexual advances
- Offering employment benefits in exchange for sexual favors
- Actual or threatened retaliation
- Leering; making sexual gestures; or displaying sexually suggestive objects, pictures, cartoons, or posters
- Making or using derogatory comments, epithets, slurs, or jokes
- Sexual comments including graphic comments about an individual's body; sexually degrading words used to describe an individual; or suggestive or obscene letters, notes, or invitations
- Physical touching or assault, as well as impeding or blocking movements
- Sexual desire is not necessary



The mission of the Department of Fair Employment and Housing is to protect the people of California from unlawful discrimination in employment, housing and public accommodations, and from the perpetration of acts of hate violence.

Employers' Obligations

All employers must take the following actions against harassment:

- Take all reasonable steps to prevent discrimination and harassment from occurring. If harassment does occur, take effective action to stop any further harassment and to correct any effects of the harassment.
- Develop and implement a sexual harassment prevention policy with a procedure for employees to make complaints and for the employer to investigate complaints. Policies should include provisions to:
- Fully inform the complainant of his/her rights and any obligations to secure those rights.
- Fully and effectively investigate. The investigation must be thorough, objective, and complete. Anyone with information regarding the matter should be interviewed. A determination must be made and the results communicated to the complainant, to the alleged harasser and, as appropriate, to all others directly concerned.
- Take prompt and effective corrective action if the harassment allegations are proven. The employer must take appropriate action to stop the harassment and ensure it will not continue. The employer must also communicate to the com-

plainant that action has been taken to stop the harassment from recurring. Finally, appropriate steps must be taken to remedy the complainant's damages, if any.

- Post the Department of Fair Employment and Housing (DFEH) employment poster (DFEH - 162) in the workplace (available through the DFEH publications line [916] 478-7201 or Web site).
- Distribute an information sheet on sexual harassment to all employees. An employer may either distribute this pamphlet (DFEH 185) or develop an equivalent document that meets the requirements of Government Code section 12950(b). This pamphlet may be duplicated in any quantity. **However, this pamphlet is not to be used in place of a sexual harassment prevention policy, which all employers are required to have.**
- All employees should be made aware of the seriousness of violations of the sexual harassment policy and must be cautioned against using peer pressure to discourage harassment victims from complaining.
- Employers who do business in California and employ 50 or more part-time or full-time employees must provide at least two hours of sexual harassment training every two years to each supervisory employee and to all new supervisory employees within six months of their assumption of a supervisory position.

- A program to eliminate sexual harassment from the workplace is not only required by law, but is the most practical way for an employer to avoid or limit liability if harassment should occur despite preventive efforts.

Employer Liability

All employers, regardless of the number of employees, are covered by the harassment section of the FEHA. Employers are generally liable for harassment by their supervisors or agents. Harassers, including both supervisory and non-supervisory personnel, may be held personally liable for harassing an employee or coworker or for aiding and abetting harassment.

Additionally, the law requires employers to take "all reasonable steps to prevent harassment from occurring." If an employer has failed to take such preventive measures, that employer can be held liable for the harassment. A victim may be entitled to damages, even though no employment opportunity has been denied and there is no actual loss of pay or benefits.

In addition, if an employer knows or should have known that a **non-employee** (e.g. client or customer) has sexually harassed an employee, applicant, or person providing services for the employer and fails to take immediate and appropriate corrective action, the employer may be held liable for the actions of the non-employee.

An employer might avoid liability if

- the harasser is not in a position of authority,



Fast Facts About Paid Family Leave

- Provides eligible workers with partial wage replacement when taking time off work to care for a child, parent, parent-in-law, grandparent, grandchild, sibling, spouse, or registered domestic partner.
- Provides coverage to employees who are covered by SDI (or a voluntary plan in lieu of SDI).
- Offers up to six weeks of benefits in a 12-month period.
- Provides benefits of approximately 55 percent of lost wages.
- PFL benefits are considered taxable income.
- Provides benefits but does not provide job protection or return rights.

In California, it's the law. **Paid Family Leave** **Benefits**

To apply online or for more information, visit:

www.edd.ca.gov/disability

Phone number: 1-877-238-4373

- Press 1 for English.
- Press 2 for Spanish.
- Press 3 for Cantonese.
- Press 4 for Vietnamese.
- Press 5 for Armenian.
- Press 6 for Tagalog.
- Press 7 for Punjabi.



State of California

The EDD is an equal opportunity employer/program. Auxiliary aids and services are available upon request to individuals with disabilities. Requests for services, aids, and/or alternate formats need to be made by calling 1-866-490-8879 (voice) or through the California Relay Service at 711.

This pamphlet is for general information only and does not have the force and effect of law, rule, or regulation.



**The time you need
for times like these.**
Paid Family Leave



Paid Family Leave Benefits for California Workers

There may be times in the life of a working person when they need to care for a loved one. Whether it's a working parent bonding with a newborn or an employee caring for a seriously ill child, parent, parent-in-law, grandparent, grandchild, sibling, spouse, or registered domestic partner. California's Paid Family Leave (PFL) was created for these times.



A Program Benefiting You and Your Family

California leads the nation as the first state to make it easier for employees to balance the demands of the workplace and family care needs at home. PFL benefits are based on the claimant's (care provider's) past quarterly earnings. For more information regarding maximum benefit amounts paid, read the *Disability Insurance (DI) and Paid Family Leave (PFL) Weekly Benefit Amounts in Dollar Increments form*, DE 2589, at www.edd.ca.gov/disability.

Paid Family Leave for California Employees

To qualify for PFL benefits, you must meet the following requirements:

- Be covered by State Disability Insurance (SDI) (or a voluntary plan in lieu of SDI) and have earned at least \$300 in your base period from which deductions were withheld.
- Supply medical information supporting your claim that the care recipient has a serious health condition and requires your care.
- Submit your claim no earlier than nine days, but no later than 49 days, after the first day your family care leave began.
- Provide documentation to support a claim for bonding with a new biological, adopted, or foster child.
- You may need to use up to two weeks of any earned but unused vacation leave or paid time off, if required by your employer, prior to the initial receipt of benefits.
- Serve a seven-day unpaid waiting period before benefits are paid for each different care recipient within the 12-month period.

You may not be eligible for benefits if:

- You are receiving Disability Insurance, Unemployment Insurance, or workers' compensation benefits.
- You are not working or looking for work at the time you begin your family care leave.
- You are not suffering a loss of wages.
- The need for care is not supported by the certificate of a treating physician/practitioner.
- You are in custody due to conviction of a crime.

You are entitled to:

- Know the reason and basis for decisions affecting your benefits.
- Appeal decisions about your eligibility for benefits. Appeals must be sent to PFL in writing.
- A hearing of your appeal before an Administrative Law Judge. Decisions may be further appealed to the California Unemployment Insurance Appeals Board and the courts.
- Privacy-Information about your claim will be kept confidential except for the purposes allowed by law.

PFL benefits do not provide job protection or return rights. Job protection may be provided if your employer is subject to the federal Family Medical Leave Act and the California Family Rights Act. Notify your employer of the reason for taking leave in a manner consistent with your company's leave policy.



Apply for Benefits

Apply for PFL benefits online at www.edd.ca.gov/disability. Employers and physicians/practitioners can submit claim information through SDI Online. You may also file using a paper form. To request a claim form, visit www.edd.ca.gov/disability.

If you are currently receiving DI pregnancy-related benefits, it is not necessary to request a PFL claim form. Claim filing information will be sent through your SDI Online account or a claim form will be sent via mail when your pregnancy-related disability claim ends.

If you are covered by a Voluntary Plan, contact your employer to obtain information about your coverage and instructions on how to apply for benefits

Contact Paid Family Leave

For questions about PFL benefits, please visit www.edd.ca.gov/disability.

The phone number is located on the back panel.

Claim forms should be mailed to PFL at:
P.O. Box 989315,
West Sacramento, CA 95798-9315

DI Office Locations & Mailing Addresses

- Chico 645 Salem Street
(PO Box 8190, Chico, CA 95927-8190)
- Chino Hills ... 15315 Fairfield Ranch Road, Ste. 100
(PO Box 60006, City of Industry, CA 91716-0006)
- Fresno 2550 Mariposa Mall, Rm. 1080A
(PO Box 32, Fresno, CA 93707-0032)
- Long Beach ... 4300 Long Beach Blvd., Ste. 600
(PO Box 469, Long Beach, CA 90801-0469)
- Los Angeles 888 S. Figueroa Street, Ste. 200
(PO Box 513096, Los Angeles, CA 90051-1096)
- Oakland 7677 Oakport Street, Ste. 325
(PO Box 1857, Oakland, CA 94606-1857)
- Riverside 1190 Palmyrita Avenue, Ste. 100
(PO Box 59903, Riverside, CA 92517-9903)
- Sacramento 5009 Broadway
(PO Box 13140, Sacramento, CA 95813-3140)
- San Bernardino 371 West 3rd Street
(PO Box 781, San Bernardino, CA 92402-0781)
- San Diego ... 9246 Lightwave Avenue, Bldg. A, Ste. 300
(PO Box 120831, San Diego, CA 92112-0831)
- San Francisco 745 Franklin Street, Rm. 300
(PO Box 193534, San Francisco, CA 94119-3534)
- San Jose..... 297 West Hedding Street
(PO Box 637, San Jose, CA 95106-0637)
- Santa Ana ... 605 West Santa Ana Blvd., Bldg. 28, Rm. 735
(PO Box 1466, Santa Ana, CA 92702-1466)
- Santa Barbara 128 East Ortega Street
(PO Box 1529, Santa Barbara, CA 93102-1529)
- Santa Rosa 606 Healdsburg Avenue
(PO Box 700, Santa Rosa, CA 95402-0700)
- Stockton 3127 Transworld Dr., Ste. 150
(PO Box 201006, Stockton, CA 95201-9006)
- California State Government Employees
(PO Box 2168, Stockton, CA 95201-2168)
- Van Nuys 15400 Sherman Way, Rm. 500
(PO Box 10402, Van Nuys, CA 91410-0402)



STATE OF CALIFORNIA

LABOR AND WORKFORCE DEVELOPMENT AGENCY

EMPLOYMENT DEVELOPMENT DEPARTMENT

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rule or regulation.*

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DISABILITY
INSURANCE
PROVISIONS



Disability is an illness or injury, either physical or mental, which prevents customary work. Disability includes elective surgery, pregnancy, childbirth, or related medical conditions.

Disability Insurance (DI) is a component of the State Disability Insurance (SDI) program, designed to partially replace wages lost due to a non-work-related disability (see “Other Programs,” for job-related disabilities).

SDI contributions are paid by California workers covered by the SDI program. Contribution rates may vary from year to year. For current rates, visit the DI website at www.edd.ca.gov/disability, or contact the Employment Development Department (EDD) Disability Insurance customer service at 1-800-480-3287 or EDD employment tax customer service at 1-888-745-3886.

DI Plans

- State Plan. The DI state plan is covered in this brochure.
- Voluntary Plan (VP). A private plan, approved by the Director of the EDD, which may be substituted for the State Plan. Voluntary Plans may be established if the employer and majority of employees agree to do so. VP information and filing a claim may be done through your employer. If you are covered by a VP, the provisions of this brochure may not apply to you. Obtain information about your coverage and file a VP claim through your employer.
- Elective Coverage (EC). Employers and self-employed persons, including general partners, may elect coverage. The method of computing benefits for EC participants is not the same as for mandatory rate payers. The cost of participating, which is set annually, can be obtained from your local EDD Employment Tax Customer Service Office.

EC claims are filed in the same manner as State Plan claims; however, there are some differences in eligibility requirements from those listed in this pamphlet.

- For additional information or to apply for coverage, contact EDD DI customer service at 1-800-480-3287, EDD employment tax customer service at 1-888-745-3886, or visit our website at www.edd.ca.gov/disability.

How to Claim State Plan Benefits

1. Use **SDI Online** to securely file for benefits or request a paper claim form.
 - By Internet: www.edd.ca.gov/disability.
 - By phone: **1-800-480-3287**.
 - By mail: EDD, Disability Insurance, PO Box 989777, West Sacramento, CA 95798-9777.
 - In person by visiting any of the DI offices listed under “DI Office Locations.”
 - California state government employees covered by SDI should call **1-866-352-7675**.
2. When filing SDI Online, complete all required fields. A receipt number will be generated when your claim is submitted.

If using a paper claim form, complete and sign the “Claim Statement of Employee.” Print clearly, and verify your answers are complete and correct as errors delay payments.
3. Have your physician/practitioner complete the “Physician/Practitioner Certification” online or use the paper claim form. If filing online, your physician/practitioner will need your receipt number to complete the “Physician/Practitioner Certification.”

Usually a claim cannot begin more than seven days before you were examined by or under the care of a physician/practitioner. Certification may be made by a licensed medical or osteopathic physician and surgeon, nurse practitioner, chiropractor, dentist, podiatrist, optometrist, designated psychologist, or an authorized medical officer of a United States government facility. Certification may also be made by a licensed nurse-midwife or licensed midwife for disabilities related to normal pregnancy or childbirth.
4. File online or submit your paper claim form within 49 days from the first day you were disabled. If your claim is late, you may lose benefits unless your explanation of the delay is accepted as reasonable.

How Benefits Are Paid

- The SDI benefits are paid electronically or by mail. You do not need to appear in person to apply or receive benefits.
- Benefits are paid via the EDD Debit CardSM. The EDD Debit CardSM works like other debit cards, giving you access to funds 24 hours a day, 7 days a week, and can be used everywhere Visa[®] debit cards are accepted. When your claim is received, you may be contacted through SDI Online, by phone, or by mail for additional information. Most properly completed claims are processed within 14 days.
- The first seven days of your DI claim are a non-payable waiting period.

Benefits are paid as quickly as possible after all information to determine eligibility is received. If you meet all eligibility requirements, benefits will be authorized. If you are eligible for further benefits, you will be authorized additional benefits electronically or sent a “continued claim” certification form for you to complete for the next benefit period. Usually these benefit periods are for two-week intervals. However, DI pays benefits based on daily eligibility within a seven-day calendar week. Partial weeks are paid at a daily rate. This rate is one-seventh of your weekly benefit amount. Please allow 10 days from the date you mail or electronically submit a certification for receipt of payment.

How Your Benefit Rate is Determined

Benefit amounts are based on wages paid during a specific 12-month **base period**, determined by the date your claim begins. Consider when to start your claim since this may affect your weekly benefit rate, your maximum benefit amount, and the period of your benefit eligibility. Only **base period** wages subject to the SDI contributions can be used in computing your benefits. To qualify, you must have earned at least \$300 during your base period. The month your claim begins determines which four consecutive quarters are used.

If your claim begins in:

- **January, February, or March, your base period is the 12 months ending last September 30.** (Example: A claim beginning February 14, 2015,

uses a base period of October 1, 2013, through September 30, 2014.)

- **April, May, or June, your base period is the 12 months ending last December 31.** (Example: A claim beginning June 20, 2015, uses a base period of January 1, 2014, through December 31, 2014.)
- **July, August, or September, your base period is the 12 months ending last March 31.** (Example: A claim beginning September 27, 2015, uses a base period of April 1, 2014, through March 31, 2015.)
- **October, November, or December, your base period is the 12 months ending last June 30.** (Example: A claim beginning November 2, 2015, uses a base period of July 1, 2014, through June 30, 2015.)

Exceptions: If your claim is determined to be invalid, but you were unemployed and seeking work for 60 days or more in any quarter of your base period, you may be able to substitute wages paid in prior quarters.

You may be entitled to substitute wages paid in prior quarters to either validate your claim or increase your benefit amount, if during your base period you:

- were in the military service.
- received workers’ compensation benefits.
- did not work because of a labor dispute.

If your situation fits any of the above, include a letter and supporting documentation with your claim form.

Wage Continuation. If your employer continues to pay you wages while you are disabled, your DI benefits may be affected. DI benefits plus wages cannot exceed your regular weekly wage. DI benefits are not affected by vacation pay you may receive.

Maximum Benefits. The maximum benefit amount is 52 times the weekly rate, but not more than your total base period wages. Exception: For employers and self-employed individuals who elect SDI coverage, the maximum benefit amount is 39 times the weekly rate.

Additionally, benefits are payable only for a limited period to a resident in an alcoholic

recovery home or drug-free residential facility that is both licensed and certified by the state in which the facility is located. However, disabilities related to or caused by acute or chronic alcoholism or drug abuse, being medically treated, do not have this limitation.

Pregnancy. As with any medical condition, your disability period begins the first day you are unable to do your regular or customary work. DI benefits are based on the period of time your physician/practitioner certifies you are unable to do your regular or customary work. Do not send in your claim for pregnancy-related DI benefits until the date your physician/practitioner certifies you are disabled.

NOTE: For information on Paid Family Leave (PFL) bonding benefits, see the “Other Programs” section of this brochure.

You May Not be Eligible for Benefits

- If you are receiving Unemployment Insurance or PFL benefits.
- If you are not working or looking for work at the time you become disabled.
- If you are in custody due to conviction of a crime.
- If your full wages are paid.
- If you are receiving workers’ compensation at a weekly rate equal to or greater than the DI rate. If workers’ compensation benefits are paid at a lower rate than your DI rate, you may be paid the difference.
- For the amount of time a claim is late (without good cause).
- If you make a false statement or fail to report a material fact. (A 30 percent penalty may be assessed if benefits are overpaid because you willfully withheld a material fact or made a false statement.)
- If you fail to attend an independent medical examination when requested. (Fees for such examinations are paid by the EDD.)

The California Unemployment Insurance Code provides for penalties consisting of fines, imprisonment, and loss of benefit rights for fraud against the SDI program.

Your Rights. You are entitled to:

- Know the reason and basis for any decision that affects your benefits.
- Appeal any decision about your eligibility for benefits. (Appeals must be sent to the DI office in writing.)
- Request an appeal hearing before an Administrative Law Judge (ALJ). You may further appeal the ALJ’s decision to the California Unemployment Insurance Appeals Board and the courts.
- Privacy – all claim information will be kept confidential except for the purposes allowed by law.

Your Obligations. Your responsibilities:

- Complete your claim and other forms correctly, completely, and truthfully.
- Submit your claim and other forms according to time limits on forms. If your claim is submitted late and you believe you have a good reason for being late, you should include a written explanation of the reason(s) with the form.
- Contact DI if you do not understand a question or how to answer it.
- Include your name and Social Security number on letters to DI.

Contact DI

- By **e-mail** at **https://askedd.edd.ca.gov**
- By phone at:
 - English 1-800-480-3287
 - Spanish 1-866-658-8846
- By **U.S. mail** addressed to PO Box 13140, Sacramento, CA 95813-3140. If you do not have a current claim, you may write to any DI office. Note: Do not mail claim forms to this PO Box.
- By **TTY** (teletypewriter for deaf, hearing-impaired, and speech-impaired persons only) at 1-800-563-2441.
- **In person** by visiting any of the DI offices listed under “DI Office Locations.”

Other Programs

If you are injured on the job or become ill as a result of your occupation, notify your employer.

If you are able and available to work but unemployed, contact the Unemployment Insurance program of the EDD through the website at **www.edd.ca.gov/unemployment**, or by phone at 1-800-300-5616 (TTY 1-800-815-9387).

If you need help in finding work, job training, retraining, or other services in order to return to work, visit your local America’s Job Center of CaliforniaSM formerly known as One-Stop Career Centers listed at **www.servicelocator.org**, or in the white pages of your phone directory.

If your disability is permanent or is expected to continue for a year or more, contact the U.S. Social Security Administration at **www.ssa.gov**, or by phone at 1-800-772-1213 (TTY 1-800-325-0778).

If you take time off work to care for a family member or if you take time off from work to bond with a new child, including newly adopted, newly placed foster children, or those of your registered domestic partner, contact the EDD PFL program at **www.edd.ca.gov/disability**, or by phone at 1-877-238-4373, or through the California Relay Service at 711.

Note: A PFL bonding claim form will be sent automatically with the final benefit payment to new mothers receiving DI benefits.

If you are a victim of a crime, contact the California Victim Compensation program at 1-800-777-9229 (TTY 1-800-735-2929). You may also contact your county Victim/Witness Assistance Center.

Questions about spousal or parental support obligations should be directed to the district attorney’s office for the county that issued the court order.

Questions about child support obligations should be directed to the Department of Child Support Services at 1-866-901-3212 (TTY 1-866-399-4096).

Earned Income Tax Credit

Based on your annual earnings, you may be eligible to receive the earned income tax credit from the federal government. The earned income tax credit is a refundable federal income tax credit for low-income working individuals and families. The earned income tax credit has no effect on certain welfare benefits. In most cases, earned income tax credit payments will not be used to determine eligibility for Medicaid, supplemental security income, food stamps, low-income housing or most temporary assistance for needy families' payments. Even if you do not owe federal taxes, you must file a tax return to receive the earned income tax credit.

Be sure to fill out the earned income tax credit form in the federal income tax return booklet. For information regarding your eligibility to receive the earned income tax credit, including information on how to obtain the IRS Notice 797, or any other necessary forms and instructions, contact the Internal Revenue Service at 1-800-829-3676 or through its Web site at www.irs.gov.



Time of Hire Pamphlet



This pamphlet may be given to all newly hired employees in the State of California. Employers and claims administrators may use the content of this document and put their logos and additional information on it.

What is *workers' compensation?*

If you get hurt on the job, your employer is required by law to pay for workers' compensation benefits. You could get hurt by:

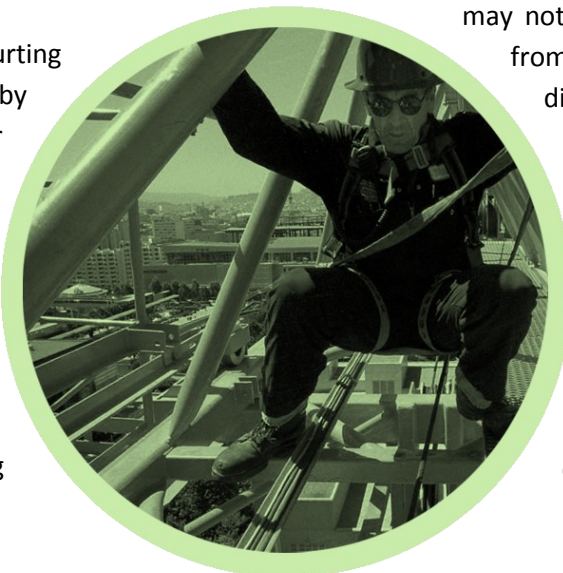
One event at work. Examples: hurting your back in a fall, getting burned by a chemical that splashes on your skin, getting hurt in a car accident while making deliveries.

—or—

Repeated exposures at work. Examples: hurting your wrist from doing the same motion over and over, losing your hearing because of constant loud noise.

—or—

Workplace crime. Examples: you get hurt in a store robbery, physically attacked by an unhappy customer.



TEMPORARY DISABILITY BENEFITS: Payments if you lose wages because your injury prevents you from doing your usual job while recovering. The amount you may get is up to two-thirds of your wages. There are minimum and maximum payment limits set by state law. You will be paid every two weeks if you are eligible. For most injuries, payments may not exceed 104 weeks within five years from your date of injury. Temporary disability (TD) stops when you return to work, or when the doctor releases you for work, or says your injury has improved as much as it's going to. You may file a claim with the Employment Development Department to get additional state disability benefits when TD benefits are delayed, denied or have ended.

What are *the benefits?*

MEDICAL CARE: Paid for by your employer to help you recover from an injury or illness caused by work. Doctor visits, hospital services, physical therapy, lab tests and x-rays are some of the medical services that may be provided. These services should be necessary to treat your injury. There are limits on some services such as physical therapy and chiropractic care.

DISCRIMINATION IS ILLEGAL



It is illegal under Labor Code section 132a for your employer to punish or fire you because:

- You file a workers' compensation claim
- Intend to file a workers' compensation claim
- Settle a workers' compensation claim
- Testify or intend to testify for another injured worker.

If it is found that your employer discriminated against you, he or she may be ordered to return you to your job. Your employer may also be made to pay for lost wages, increased workers' compensation benefits, costs and expenses set by state law.

PERMANENT DISABILITY BENEFITS: Payments if you don't recover completely. The amount of payment is based on:

- Your doctor's medical reports
- Your age
- Your occupation
- How much you can earn in the future.

You will be paid every two weeks if you are eligible. There are minimum and maximum weekly payment rates.

SUPPLEMENTAL JOB DISPLACEMENT BENEFITS:

Vouchers to help pay for retraining or skill enhancement if you don't recover completely and don't return to work for your employer. The vouchers range from \$4,000 to \$10,000 depending on your level of permanent disability. This voucher is for you to use at a state approved school if:

- You have a permanent disability
- Your employer does not offer modified or alternative work and
- You don't return to your employer within 60 days after your TD ends.

DEATH BENEFITS: Payments to your spouse, children or other dependents if you die from a job injury or illness. The amount of payment is based on the number of dependents. The benefit is paid every two weeks at a rate of at least \$224 per week. In addition, workers' compensation provides a burial allowance.

WORKERS' COMPENSATION FRAUD IS A CRIME

Any person who makes or causes to be made any knowingly false statement in order to obtain or deny workers' compensation benefits or payments is guilty of a felony. If convicted, the person will have to pay fines up to \$150,000 and/or serve up to five years in jail.

**What should I do
if I have an injury?**

REPORT YOUR INJURY TO YOUR EMPLOYER

Tell your supervisor right away no matter how slight the injury may be. Don't delay — there are time limits. You could lose your right to benefits if your employer does not learn of your injury within 30 days. If your injury or illness is one that develops over time, report it as soon as you learn it was caused by your job.

WHO IS MY CLAIMS ADMINISTRATOR?

Workers' compensation claims administrator, or if employer is self-insured, person responsible for handling the claim is:

Address: _____

Phone: _____

GET EMERGENCY TREATMENT IF NEEDED

If it's a medical emergency, go to an emergency room right away. Tell the medical provider who treats you that your injury is job related. Your employer may tell you where to go for follow up treatment.

EMERGENCY TELEPHONE NUMBER:

Call 911 for an ambulance, fire department or police. For non-emergency medical care, contact your employer, the workers' compensation claims administrator or go to this facility:

FILL OUT DWC 1 CLAIM FORM AND GIVE IT TO YOUR EMPLOYER

Your employer must give you a [DWC 1 claim form](#) within one working day after learning about your injury or illness. Complete the employee portion, sign and give it back to your employer. Your employer will then file your claim with the claims administrator. Your employer must authorize treatment within one working day of receiving the DWC 1 claim form.

If the injury is from repeated exposures, you have one year from when you realized your injury was job related to file a claim.

In either case you may receive up to \$10,000 in employer-paid medical care until your claim is either accepted or denied. The claims administrator has up to 90 days to decide whether to accept or deny your claim. Otherwise your case is presumed payable.

Your employer or the claims administrator will send you “benefit notices” that will advise you of the status of your claim.



What is a primary treating physician (PTP)?

This is the doctor with overall responsibility for treating your injury or illness. He or she may be:

- The doctor you name in writing *before* you get hurt on the job
- A doctor from the medical provider network (MPN)
- The doctor chosen by your employer during the first 30 days of injury if your employer does not have an MPN or
- The doctor you chose after the first 30 days if your employer does not have an MPN.

What is a medical provider network (MPN)?

An MPN is a select group of health care providers who treat injured workers. Each MPN includes a mix of doctors specializing in work-related injuries and doctors with expertise in general areas of medicine. Check with your employer to see if they are using an MPN.

If you have not named a doctor before you get hurt and your employer is using an MPN, you will see an MPN doctor. After your first visit, you are free to choose another doctor from the MPN list. A complete MPN notice must be posted in a work area used by employees and near the “Notice to Employees” poster. For more information, see the MPN contact on the “Notice to Employees” poster.

What is predesignation?

Predesignation is when you name your regular doctor to treat you if you get hurt on the job. The doctor must be a medical doctor (M.D.), doctor of osteopathic medicine (D.O.) or a medical group with an M.D. or D.O. You must name your doctor in writing *before* you get hurt or become ill.

You may predesignate a doctor if your employer offers group health coverage and the doctor must have:

- Treated you
- Maintained your medical history and records before your injury and
- Agreed to treat you for a work-related injury or illness before you get hurt or become ill.

You may use the “predesignation of personal physician” form included with this pamphlet. After you fill in the form, be sure to give it to your employer.

If your employer does not have an approved MPN, you may name your chiropractor or acupuncturist to treat you for work related injuries. The notice of personal chiropractor or acupuncturist must be in writing *before* you get hurt. You may use the form included in this pamphlet. After you fill in the form, be sure to give it to your employer.

What if there is a *problem with my benefits?*

If you have a concern, speak up. Talk to your employer or the claims administrator handling your claim and try to solve the problem. If this doesn't work, get help by trying the following:

CONTACT THE DIVISION OF WORKERS' COMPENSATION (DWC) INFORMATION AND ASSISTANCE (I&A) UNIT

All 24 DWC offices throughout the state provide information and assistance on rights, benefits and obligations under California's workers' compensation laws. I&A officers help resolve disputes without formal proceedings. Their goal is to get you full and timely benefits. Their services are free.

To contact the nearest I&A Unit, go to www.dwc.ca.gov in the top bar, click on "I&A." At this site you will find fact sheets, guides and information to help you.

THE NEAREST I&A UNIT IS LOCATED AT:

Address: _____

Phone: _____

CONSULT WITH AN ATTORNEY

Most attorneys offer one free consultation. If you decide to hire an attorney, his or her fees may be taken out of some of your benefits. For names of workers' compensation attorneys, call the State Bar of California at (415) 538-2120 or go to their Web site at www.californiaspecialist.org. You may get a list of attorneys from your local I&A Unit or look in the yellow pages.



WARNING



Your employer may not pay workers' compensation benefits if you get hurt in a voluntary off-duty recreational, social or athletic activity that is not part of your work-related duties.

ADDITIONAL RIGHTS



You may also have other rights under the Americans with Disabilities Act (ADA) or the Fair Employment and Housing Act (FEHA). For additional information, contact FEHA at (800) 884-1684 or the Equal Employment Opportunity Commission (EEOC) at (800) 669-4000.

The information contained in this pamphlet conforms to the informational requirements found in Labor Code sections 3551 and 3553 and California Code of Regulation, Title 8, sections 9880 and 9883. This document is approved by the Division of Workers' Compensation administrative director.

INFORMATION & ASSISTANCE UNIT LOCATIONS

By phone at [1-800-736-7401](tel:1-800-736-7401) -- For recorded information that helps injured workers, employers and others understand California's workers' compensation system, and their rights and responsibilities under the law.

- By [attending a workshop](#) for injured workers
- By calling or going in person to a local Information & Assistance Unit office:

Anaheim

1065 N. Pacific Center Drive
Anaheim 92806-2141
(714) 414-1801

Bakersfield

1800 30th Street,
Suite 100
Bakersfield, CA 93301-1929
(661) 395-2514

Eureka

* Satellite office
100 "H" Street,
Room 202
Eureka, CA 95501-0481
(707) 441-5723

Fresno

2550 Mariposa Mall,
Room 5005
Fresno, CA 93721-2219
(559) 445-5355

Long Beach

300 Ocean Gate Street,
Suite 200
Long Beach, CA 90802-4304
(562) 590-5240

Los Angeles

320 W. 4th Street,
9th floor
Los Angeles, CA 90013-1954
(213) 576-7389

Marina del Rey

4720 Lincoln Blvd
2nd floor
Marina del Rey, CA 90292-6902
(310) 482-3820

Oakland

1515 Clay Street,
6th floor
Oakland, CA 94612-1519
(510) 622-2861

Oxnard

1901 N. Rice Ave., Ste. 200
Oxnard, CA 93030-7912
(805) 485-3528

Pomona

732 Corporate Center Drive
Pomona, CA 91768-2653
(909) 623-8568

Redding

250 Hemsted Drive,
Second Floor, Ste. B
Redding, CA 96002
(530) 225-2047

Riverside

3737 Main Street,
Room 300
Riverside, CA 92501-3337
(951) 782-4347

Sacramento

160 Promenade Circle,
Suite 300
Sacramento, CA 95834-2962
(916) 928-3158

Salinas

1880 North Main Street,
Suite 100
Salinas, CA 93906-2037
(831) 443-3058

San Bernardino

464 W. Fourth Street,
Suite 239
San Bernardino, CA 92401-1411
(909) 383-4522

San Diego

7575 Metropolitan Drive,
Suite 202
San Diego, CA 92108-4424
(619) 767-2082

San Francisco

455 Golden Gate Avenue,
2nd floor
San Francisco, CA 94102-7014
(415) 703-5020

San Jose

100 Paseo de San Antonio,
Room 241
San Jose, CA 95113-1402
(408) 277-1292

San Luis Obispo

4740 Allene Way,
Suite 100
San Luis Obispo, CA 93401-8736
(805) 596-4159

Santa Ana

605 W Santa Ana Blvd, Bldg 28
Room 451
Santa Ana, CA 92701-4070
(714) 558-4597

Santa Barbara

* Satellite office
411 E Canon Perdido Street,
Suite 2
Santa Barbara, CA 93101
(805) 884-1988

Santa Rosa

50 "D" Street,
Room 420
Santa Rosa, CA 95404-4771
(707) 576-2452

Stockton

31 East Channel Street,
Room 344
Stockton, CA 95202-2314
(209) 948-7980

Van Nuys

6150 Van Nuys Blvd.,
Room 105
Van Nuys, CA 91401-3370
(818) 901-5367

ACKNOWLEDGEMENT
7/11

DRUG-FREE WORKPLACE POLICY

I, _____, hereby acknowledge that I have read and understand the Drug-free Workplace Policy of 7/11, which outlines the company's policy regarding the use or possession of drugs and related items. I understand that the company, under certain circumstances, will require employees to submit to a drug screening to be analyzed for the presence of drugs and/or alcohol. I realize that the presence of a detectable trace of any unauthorized substance is grounds for disciplinary action and that this may include termination of my employment. I further realize that my cooperation is voluntary and that refusal to submit to the drug screening is grounds for my termination.

I agree to cooperate and abide by this policy and understand that any failure to do so on my part is grounds for termination.

Employee Signature

Date

Supervisor/Manager Signature

Date

**EMPLOYEE DRUG SCREEN
CONSENT AND RELEASE FORM**

Name: _____ Date: _____

Dept: _____

I understand that, in accordance with 7/11 policy of providing and maintaining a safe and healthful working environment for all employees, I will voluntarily submit to a drug or alcohol screen test.

I hereby authorize the release of the results of the test to 7/11 and its designated medical representatives.

I release 7/11, its employees, management, and its designated medical representatives from any and all claims or causes of action resulting from the release of the test results.

Employee Signature

Date

Witness Signature

Reasonable Cause Testing Checklist 7/11

This form is to be used to document the reasons for requesting that an employee be asked to submit a drug and alcohol screen test. All questions that apply should be answered. Additional pages, if necessary, should be attached with any other relevant documents.

Employee name: _____ Position: _____
Client: _____ Dept: _____

1. Was there an incident? Yes No

If yes, please describe event (include date, time and place, employee's actions, and extent of any injury to any person(s) or property):

2. Is employee in safety-sensitive position? Yes No

3. Observation of Employee Date: _____ Time: _____

a. Walking

Falling Holding on Staggering
Stumbling
Swaying Unsteady Unstable to walk

b. Standing

Feet wide apart Rigid Swaying Sagging at
knees
Staggering Unable to stand

c. Speech

Mute Slurred Slow Shouting
Silent Incoherent Rambling Slobbering
Whispering

d. Demeanor

Fighting Crying Sleepy Sarcastic
Talkative Silent Excited

e. Actions

Fighting	Profane	Drowsy	Hostile
Hyperactive	Erratic	Threatening	
Resisting communication			

f. Eyes

Bloodshot	Closed	Dilated	Droopy
Glassy		Watery	

g. Face/Nose

Flushed	Pale	Sweaty	Runny
Sores			

h. Appearance/Clothing

Unruly dressed	Dirty	Messy	Partially
Having odor	Bodily stains on clothing		
Wearing sunglasses indoors or in all kinds of weather			

i. Breath

Alcohol odor	Marijuana odor
--------------	----------------

j. Movements

Fumbling	Jerky	Nervous	Slow
Hyperactive	Vomiting	Nausea	
Excessive perspiration			

4. Attendance

- a. Number of Mondays or Fridays missed in last two months: _____
- b. Total absences in last two months: _____
- c. Times tardy in last two months: _____
- d. Times employee left early in last two months: _____

5. Performance level

- a. Has there been a recent change in the employee's level of performance?

Yes	No
-----	----

- b. If yes, Describe: _____

6. Other observations: _____

7. Other factors: _____

8. Other witnesses: _____

Supervisor Name (Please print): _____

Supervisor Signature: _____

Witness Name(s) and Initial(s): _____

Date: _____

7/11
DRUG-FREE WORKPLACE POLICY

OBJECTIVE

The purpose of this policy is to set forth general guidelines to be followed in implementing the company's drug-free workplace policy as it applies to employees, contractors, visitors, and non-employees.

PROCEDURE

General

7/11 has a strong commitment to providing a safe workplace and establishing programs promoting high standards of employee health and safety. The company is concerned about the use of alcohol, illegal drugs, or controlled substances as it affects the workplace. Use of these substances can adversely affect an employee's work performance, efficiency, safety and health, and therefore, seriously impair the employee's value to the company, as explained in the employee handbook.

In addition, the possession, sale, manufacturing, distribution or use of these substances on the job constitutes a potential danger to the welfare and safety of others, exposes the company to the risks of property loss or damage, or injury to other persons. All employees are encouraged to report any drug or alcohol abuse or impairments to fitness for duty.

While the company has no intention of intruding into the personal lives of its employees, it is recognized that serious involvement with drugs or alcohol off the job eventually takes a toll on job performance. Employees having a drug or alcohol problem are strongly encouraged to seek treatment and or rehabilitation.

Company Policy on Illegal Drugs and Alcoholic Beverages

Illegal Drugs-

The possession, sale, manufacturing, distribution or use of illegal drugs (defined as any drug or drug-like substance whose sale, use or possession is unlawful) is inconsistent with the company's objective of operating in a safe and efficient manner. Accordingly, no officer,

employee, agent, contractor or visitor shall use, or have in his or her possession, illegal drugs during working hours or on company property at any time. Additionally, no officer, employee, agent or contractor shall report to work while under the influence of illegal drugs. The services of any employee who engages in such conduct will be subject to disciplinary action up to and including discharge, according to vested authority. The only exception is taking of prescribed drugs under the direction of a physician.

The unlawful involvement with drugs or narcotics off company property will constitute grounds for severe disciplinary action up to and including termination of employment.

Alcoholic Beverages-

The use of alcoholic beverages by employees or contractors engaged in the construction, operation or maintenance of the company's facilities is inconsistent with the objective of operating in a safe and efficient manner. Accordingly, no officer, employee, agent, visitor or contractor shall use alcoholic beverages during working hours nor shall alcoholic beverages be served at a company function without prior approval by the appropriate senior officer of the company as designated by the chief executive officer. Additionally, no officer, employee, agent or contractor shall report to work under the influence of alcoholic beverages. Employees in violation of this policy will be subject to disciplinary action up to and including termination of employment, according to vested authority.

Drug and Alcohol Testing

Pre-employment Drug Screening:

All applicants following an offer of employment will be required to submit to a drug screening. All applicants will be requested to sign a consent release form authorizing the clinic to perform the drug screening and submit the results to the company. Applicants who refuse to sign the consent release form or who show traces of illegal drugs or controlled substances will not be considered for employment. The company will communicate positive results from the drug screening only to the applicant. In the event the results are positive for non-prescribed, illegal or alcoholic substances, the offer of employment will be retracted.

Reasonable Suspicion:

Where there is reasonable suspicion of illegal drugs, controlled substance or alcohol use which adversely impacts an employee's performance or behavior on the job (or off the job if such use adversely affects an employee's job performance, safety, or health) the company will require the employee to undergo testing for controlled substances or alcohol use, and to consent to have the results of the test released to the company.

Reasonable suspicion of illegal drugs, controlled substances or alcohol use on the job may be based on appropriate factors, including, but not limited to: absenteeism and other attendance problems, poor work performance, the finding of illegal drugs, controlled substances or alcohol on the work premises, or erratic behavior on the job, coupled with one or more signs, including, but not limited to:

Employees who are requested to submit to a drug screening will be asked to sign a consent release form authorizing the clinic to conduct the test and submit the results to the company. Employees who refuse to sign a consent release form or who are tested positive as having prohibited substances in their system may be disciplined up to and including discharge, according to vested authority.

Post accident:

After every work-related accident, the employee(s) involved will be required to submit to a drug screening. The exception to this will be the first-aid type of injuries or accidents. Employees must report all work-related accidents or injuries immediately to a supervisor or manager.

Employees will be asked to sign a consent release form authorizing the clinic to conduct the test and submit the results to the company. Employees who refuse to sign the consent release form or who are identified as having prohibited substances in their system may be disciplined up to and including discharge, according to vested authority.

7/11 is committed to establishing a drug-free workplace and will need everyone's cooperation to make this successful. Thank you for your time and attention.