FRONTLINE HRO

effective strategies & customized coverage

NEW HIRE BOOKLET

Client Name: _____

Address: _____

_____

City State Zip

Employee Name: _____

Employee Signature: _____

Last Name First Name

Employee Email: _____

Date: _____

FRONTLINE HRO
effective strategies & customized coverage

WELCOME

This is an equal employment opportunity employer. We adhere to a policy of making employment decisions without regard to race, color, sex, religion, national origin, handicap, disability or marital status. We assure you that your opportunity for employment with this employer depends solely upon your qualifications. The also accommodates individuals with handicaps, disabilities and bona fide religious beliefs.

Employee Instructions:

1. Complete this book in its entirety
2. This booklet requires signature for successful completion and processing:
    a. New Employee Certification
    b. I-9 Employment Eligibility Certification
    c. W-4 Withholding Certificate
    d. IL W-4 Withholding Certificate (if applicable)
    e. Drug Free Workplace Policy Certification
    f. Harassment Policy Certification
    g. Safety Guidelines
    h. Direct Deposit Form
    i. Policies and Procedures

Management Instructions:

1. Verify signature on New Employee Certification page.
2. Complete the I-9 Employment Eligibility Verification and have an Authorized Representative sign Box 2.
3. Federal Withholding Certificate must be completed; verify number listed on the line; verify signature.
4. IL W-4 Withholding Certificate must be completed; verify number listed on line 1; verify signature. (if applicable)
5. Visually verify and make copies of documents used to verify employee's employment eligibility.
6. Drug Free Workplace clients must verify and witness employee's signature. Provide employees with appropriate paperwork and direct them to the appropriate facilities for testing.
7. Verify signature on Harassment Policy Certification.
8. Verify signature on Safety Guidelines.
9. If employee wishes to use Direct Deposit, make sure to attach a voided check along with the signed form.

FRONTLINE HRO
effective strategies & customized coverage

NEW EMPLOYEE CERTIFICATION

I affirm and certify that an offer of employment has been made to me, conditioned on the satisfactory completion of this New Hire Booklet and that all information given herein and in my interview(s) with the is true and correct to the best of my knowledge. I pledge to abide by all policies, procedures and safety rules.

I understand that if I am hired, my employment with the will not be for a specific term and may be terminated by me or the with or without notice or cause at any time. I further understand that no oral promise, policy, custom business proactive or other procedure (including the 's Employee Handbook or any personnel manuals) shall constitute and employment contract or modification of the at-will employment relationship between me and the .

I acknowledge that as a condition of employment the has the right to and may require drug and alcohol testing. The testing will be at the 's expense. I agree to submit to such testing if asked to do so.

I agree to abide by the direction and supervision of management in regards to the day-to-day operation of my duties, including by not limited to determination of my wages or salary levels, performance evaluations, transfers and benefits.

Last Name	First Name	Employee Signature	Date

FRONTLINE HRO
effective strategies & customized coverage

NEW EMPLOYEE INFORMATION

EMPLOYEE INFORMATION *(to be completed by employee)*

Employee Name: _____
Last First M.I.

Address: _____ Apt#: _____

_____ Phone: _____
City State Zip

Social Security Number: _____ Date of Birth: _____
mm/dd/yyyy

Drivers License Number: _____ DL Expiration Date: _____
mm/dd/yyyy

State License Held: _____

Gender: ☐ Male ☐ Female

Race: ☐ White ☐ African American ☐ Hispanic ☐ Asian/Pacific Islander
☐ American Indian

Emergency Contact:

Primary Contact: _____ Relationship: _____

Main Phone: _____ Mobile Phone: _____

Secondary Contact: _____ Relationship: _____

Main Phone: _____ Mobile Phone: _____

INFORMATION *(to be completed by employer)*

Name: _____ Job Title: _____

Email Address: _____ Start Date: _____
mm/dd/yyyy

Rate of Pay: $ _____ _____ Status: _____
Annually or Hourly Full Time / Part Time / Contact

Division: _____ WC Code: _____

FRONTLINE HRO
effective strategies & customized coverage

DRUG-FREE WORKPLACE POLICY SUMMARY

In a commitment to safeguard the health of our employees and to provide a safe working environment, we have established a Drug-Free Workplace Policy for our . This policy is set up pursuant to the Drug-Free Workplace program requirements under applicable state laws and regulations and Department of Transportation Rule 49 CFR part 40, Procedures for Transportation Workplace Drug Testing. The contents of these drug and alcohol guidelines are not intended to create a contract between the and any employee. Nothing in these guidelines binds the to a specific or definite period of employment or to any specific polices, procedures, actions, rules, terms or conditions of employment. Detail of this policy may be obtained from management.

Essential Parts of the Policy:

- Observance of this policy is a condition of continued employment.
- This policy prohibits the sale, possession, use, manufacturing, or distribution of drugs, drug paraphernalia or alcohol while working for or on assigned or owned properly, or while operating any vehicle, machinery, or equipment owned or leased by the .
- It is a violation of this policy to report to work if drugs or alcohol is found to be present in your system at or above the level prescribed by application drug testing rules.
- It is a violation of this policy to report to work, return to work, or to remain at work with the odor of alcohol on your breath, regardless of whether or not you are actually intoxicated.

Testing of Employees:

- **Reasonable Suspicion Testing:** Employees may be tested when there is reasonable suspicion that the employee is using or has used drugs while performing their assigned duties.
- **Routine fitness-for-duty testing:** Employees may be required as a condition of continued employment to be drug tested if the test is conducted as part of a routine or annual fitness-for -duty medical examination.
- **Post accident/incident testing:** Employees who cause or contribute to an accident may be required to submit to a drug test. Employees, while at work, who sustain injuries requiring medical treatment beyond first aid may be drug tested.
- **Follow up testing:** Employees who have been determined to have used drugs or alcohol, and are retained by the will be subject to unannounced follow-up drug test at least once per year for a period of up to 2 years.
- **Additional Testing:** Additional testing including random testing may also be conducted as required by applicable state or federal laws, rules or regulations or as deemed necessary by the .

Disciplinary Action:

- The may suspend employees without pay under this policy pending the results of a drug test or investigation.
- In the case of a first-time violation of this policy, when an employee has a positive drug or alcohol test result, *(without evidence of use, sale possession, distribution, dispensation, or purchase of drugs or alcohol on property or while on duty)*, the employee will be sublet to discipline up to the including discharge.
- Any employee who has a second violation of any party of this policy will discharged.
- Any employee using, selling, purchasing, distributing, or dispensing drugs or alcohol while on duty or while on property will be discharged.
- An employee who refuses to submit to drug screening may be denied continued employment.
- An employee who refuses to cooperate with a drug screening post accident will be subject to discipline up to and including discharge.
- An employee injured in a workplace accident who has a confirmed, positive rest result maybe be denied eligibility for medical and indemnity benefits as provided by applicable workers' compensation laws.
- An employee who is discharged from duty on the basis of a confirmed positive test will have their claim for unemployment compensation benefits opposed and possible denied.

Employee Rights and Responsibilities:

- Each employee will be given an opportunity, both before and after drug use screening, to confidentially report to the assigned Medical Review Officer the use of prescription and / or non-prescription medication that may alter or affect the results of a test.
- Employees have the right, upon written request, to receive a copy of the drug test result.
- Employees have the right to consult the Medical Review Officer (MRO) for technical information regarding prescription and non-prescription medication. Addresses of MRO's may be obtained from management.
- An employee who is using prescription and/or non-prescription medication which may impair the employee's ability to work safely must report this medication use to their supervisor or management before starting any work related activity. This notification will be kept strictly confidential, but failure to notify your supervisor or management may result in disciplinary action.
- All information, interviews, reports, statement memorandum and drug test results, written or otherwise, received by the as a part of this drug testing program are confidential communications. Unless authorized by state or federal laws, rules or regulations, the will not release such information without a written consent form signed voluntarily by the person tested.
- Any employee who receives a confirmed positive drug test result has the right to challenge the result.
- An employee who elects to challenge the results of a confirmed positive test result may have the original specimen retested by another qualified laboratory. All re-testing will be at the employee's expense.
- The employee has the responsibility of notifying the drug testing laboratory of any administrative or civil action brought concerning the drug test results. The lab will maintain a sample until the case of administrative appeal is settled.
- An Employee Assistant Plan/Substance Abuse Program list is available and will be provided upon request.
- The will provide employees with a period of training regarding substance abuse and this Drug-Free Workplace Policy.

Acknowledgment Signature:

I hereby acknowledge that I have received and read a summary of the 's Drug-Free Workplace Policy. I have had an opportunity to have this material fully explained.

I understand that this substance abuse testing program is established as a safety requirement in accordance with applicable state regulations. the program involves routine testing of urine, hair, blood, or other authorized samples to determine the presence of illegal drugs. These tests may be conducted at anytime by the or its agent(s) to determine that the employees meet the necessary qualifications for employment and continued employment. I also understand the Drug-Free Workplace policy and related documents are not intended to constitute a contract between the and myself.

My signature below indicated that I have read, understood, authorize and consent to the above statement and any attached addendum and hereby voluntarily participate in the substance abuse testing program.

Employee Name (printed) Employee Signature Date

Purpose:

We are committed to maintaining a work environment free of harassment on the basis of race, creed, religion, gender, sex, national origin, age, marital status, sexual preference, or disability. We will not tolerate harassment of personnel by a supervisor, co-worker, vendor, customer or anyone else. Workplace and sexual harassment may violate one of more of the following:

- Title IV of the Civil Rights Act of 1964
- Age Discrimination Employment Act
- Americans with Disabilities Act (ADA)

Any employee who engages in sexual or other unlawful harassment violates this policy and the law and will be disciplined up to and including immediate termination.

Guidelines:

Harassment is verbal or physical conduct that denigrates or shows hostility or aversion toward an individual because of their race, color, creed, religion, gender, national origin, age, marital status or disability when it:

1. Has the purpose or effect of creating an intimidating, hostile, or offensive working environment
2. Has the purpose or effect of unreasonably interfering with an individual's work performance; or
3. Otherwise adversely affects an individual's employment opportunities.

Examples of inappropriate and prohibited harassment include, but are not limited to following:

1. Epithets, slurs, negative stereotyping, or threatening, intimidating, or hostile acts that relate to race, color, religion, gender, national origin, age, marital status, sexual preference, or disability; and,
2. Written or graphic material that denigrates or shows hostility toward an individual or group because of race, color, religion, gender, national origin, age, marital status, sexual preference, or disability and that is placed on walls, bulletin boards, or elsewhere on the 's premises or circulated in the workplace. This also includes acts that purport to, or are meant to be "jokes' or "pranks" but that are hostile or demeaning, such as hate mail, threats, defaced photographs, or other such conduct.

Sexual advances, request for sexual favors and any other physical, verbal, or visual conduct of sexual nature constitute sexual harassment when:

1. Submission to the conduct is an explicit or implicit term or condition of employment or continued employment,
2. Submission or rejection of the conduct is used as a basis for employment decisions affecting an employee', such as a promotion, demotion or evaluation;
3. The conduct has purpose or effect of reasonably interfering with an employee's work performance or creating an intimidation, hostile or offensive work environment.

Sexual harassment may include, but is not limited to, unwelcome sexual propositions; sexual innuendo, suggestive remarks; vulgar or sexually explicit comments gestures or conduct; sexual oriented kidding, teasing or practical jokes; and physical contact, such as brushing against another's body, pinching or patting. Sexual and workplace harassment may be present when the intended target of conduct is not offended, but others reasonably find the conduct intimidating, hostile or abusive.

All personnel are responsible for helping to assure that the is kept free of all forms of harassment. If any person experiences or witnesses workplace harassment they have an affirmative obligation to report such conduct to their supervisor, the President or Human resources. Employees are not expected to report harassment to a person they believe is harassing them. In those situations, report the conduct to the Human Resource Department or President.

All harassment complaints will be kept confidential to the extent possible, consistent with the conduct of a full and fair investigation. Personnel violating confidentiality are subject to immediate discipline. Communications will be made to others only on a limited "need to know" basis. There will be no retaliation against any employee for filing complaints of workplace harassment, unless such accusation is shown to be intentionally false.

We are committed to promptly and thoroughly investigating all harassment complaints. If, after a thorough investigation it is determined that harassment has occurred, immediate and appropriate disciplinary action up to discharge will be taken to end the harassment. Appropriate follow-up steps will be taken to ensure the harassment has stopped. In the event an employee is not satisfied with the results of the investigation, the employee may appeal in writing to an upper executive of Frontline HRO.

Acknowledgment Signature:

I understand that the will not tolerate sexual and other forms of unlawful harassment. I understand that I have the affirmative obligation to report it. I also understand that unlawful harassment is grounds for disciplinary action up to and including immediate discharge.

Employee Name (printed) Employee Signature Date

FRONTLINE HRO

effective strategies & customized coverage

DIRECT DEPOSIT FORM

Employee Name: _____ SSN: _____

Client : _____

I hereby authorize my Payroll hereafter called Frontline HRO to initiate credit entries and to initiate, if necessary, debit entries and adjustments for any credit entries in error to the account indicated below, hereafter called DEPOSITORY, to credit and debit the same entries into such account.

Employee Signature: _____ Date: _____

Co-Signature: _____ Date: _____
(for joint accounts)

Banking Information:

Bank Name: _____ Bank Phone #: _____

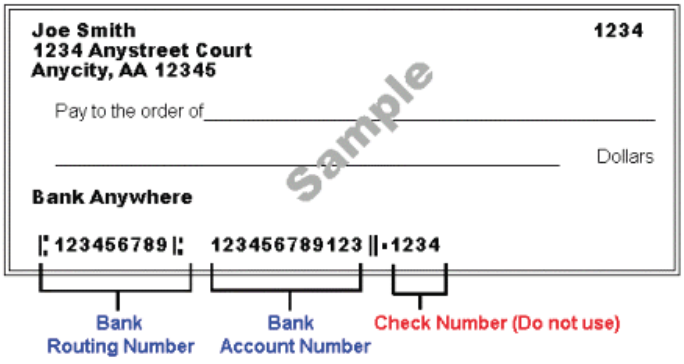
Bank Address: _____

Bank Transit:
(ABA Routing #) _____

Checking Account #: _____ Deposit Amount: _____

Savings Account #: _____ Deposit Amount: _____

Where to find your ABA routing number and account number.



Please attach:

1. Voided check or copy of a voided check for any/all checking accounts listed above. Please do not attach deposit slips, the account numbers do not always match the numbers listed on the check.
2. Savings account deposit slip for any savings account or bank letter with the necessary information to deposit the money into your appropriate account.

Please Note:

It is the employee's responsibility to notify Frontline HRO whenever there is any change in the account information, including any change in the bank routing number, account number, etc. Any change (other than amount) in account information will cause a pre-notification (verification) of account information producing a negotiable check for a two-week period.

These Safety Guidelines are provided for your information and education. They are intended to provide you with basic safety information that will assist you in avoiding injury while performing your daily activities.

General Safety Guidelines:

1. It is important that all employees report all work related injuries to their immediate supervisor as soon as possible after they become aware of the injury.
2. Everyone should exercise extreme care and consideration in the performance of their duties to see they do not cause injury to others or create work hazards that could cause injury to others.
3. No one should try to lift or move heavy/bulky objects that could cause injury to the back or other badly parts. You are requested to seek assistance.
4. Personal tools, equipment, extension cords, chemical or electrical heaters should not be brought to work without management authorization.
5. When you become aware of a facility or equipment defect, report it to the facilities manager for proper corrective action. Failure to report faulty conditions may result in injuries.
6. Never attempt to repair electrical equipment or appliances while in service. Tag them out of service and notify proper authority to affect repair.
7. Cabinets can be very dangerous if used improperly. Opening two drawers simultaneously can cause a cabinet to crash to the floor. Whenever possible, cabinets should be bolted together in tandem, secure to the floor or wall.
8. Flammable liquids should always be stored in appropriate, closed containers. Large supplies should be stored in UL-Approved cabinets or other appropriate means described by the Fire Department. Flammable liquids should never be left unattended.
9. Heavy objects should be stored on lower shelves while lighter and less dangerous items can be stored on middle and upper shelves.
10. Bookshelves, storage cabinets and other elevated storage areas should be well secured.
11. Defective furniture, worn carpet, defective chairs, loose handrails or other facility defects which could contribute to an accident should be reported to building services for proper corrective action.
12. Everyone should take time to be educated regarding emergency procedures.

Proper Lifting Techniques

1. **Posture:** Your back and neck have natural curves that should be kept flexible. Good posture maintains those curves and reduces stress on your muscles, ligaments and the shock-absorbing discs between the bones in your spine.
2. **Plan:** Lift mentally first, planning your route and the place you will put down the load. When the load is heavy or bulky, get help. Ask a co-worker or use equipment to ease the task (e.g., mechanical left, hand truck, cart, etc.)
3. **Lifting:** Establish good footing as you approach the object you intend to lift. Bend your knees, not your back and get a good grip. Plan to hold the object close to your body. Tighten your stomach as you lift. Lift smoothly with your legs, not your back.
4. **Moving:** Stand straight as you move the object. Don't twist your body while lifting; rather, turn your feet. Keep your balance. If you have a problem, ask for help. Be sure of your footing and pathway.

I HAVE THOROUGHLY READ AND UNDERSTAND THE SAFETY GUIDELINES. I WILL ALWAYS MAINTAIN SAFE WORK PRACTICES AS OUTLINED ABOVE AND WILL IMMEDIATELY REPORT ANY INFRACTION TO MY SUPERVISOR.

Name _____ Signature _____ Date _____

Employment Eligibility Verification

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

USCIS
Form I-9
OMB No. 1615-0047
Expires 10/31/2022

►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 *(See instructions)*

☐ 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. *(See instructions)*

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.

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)*

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

STOP *Employer Completes Next Page* STOP

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

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				
Issuing Authority				
Document Number				
Expiration Date *(if any) (mm/dd/yyyy)*				
Document Title				
Issuing Authority				
Document Number				
Expiration Date *(if any) (mm/dd/yyyy)*				

Additional Information

QR Code - Sections 2 & 3
Do Not Write In This Space

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

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		**1.** Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		**1.** A Social Security Account Number card, unless the card includes one of the following restrictions: (1) NOT VALID FOR EMPLOYMENT (2) VALID FOR WORK ONLY WITH INS AUTHORIZATION (3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION
2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)		**2.** ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		**2.** Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240)
3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa		**3.** School ID card with a photograph		**3.** Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal
4. Employment Authorization Document that contains a photograph (Form I-766)		**4.** Voter's registration card		**4.** Native American tribal document
5. For 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.		**5.** U.S. Military card or draft record		**5.** U.S. Citizen ID Card (Form I-197)
		6. Military dependent's ID card		**6.** Identification Card for Use of Resident Citizen in the United States (Form I-179)
		7. U.S. Coast Guard Merchant Mariner Card		**7.** Employment authorization document issued by the Department of Homeland Security
		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:		
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		**10.** School record or report card		
		11. Clinic, doctor, or hospital record		
		12. Day-care or nursery school record		

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

Refer to the instructions for more information about acceptable receipts.

Form **W-4**

Department of the Treasury
Internal Revenue Service

Employee's Withholding Certificate

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

OMB No. 1545-0074

2023

Step 1: Enter Personal Information

(a) First name and middle initial	Last name	**(b) Social security number**
Address		**Does your name match the name on your social security card?** If not, to ensure you get credit for your earnings, contact SSA at 800-772-1213 or go to *www.ssa.gov*.
City or town, state, and ZIP code		

(c) ☐ **Single** or **Married filing separately**
☐ **Married filing jointly** or **Qualifying surviving spouse**
☐ **Head of household** (Check only if you're unmarried and pay more than half the costs of keeping up a home for yourself and a qualifying individual.)

Complete Steps 2–4 ONLY if they apply to you; otherwise, skip to Step 5. See page 2 for more information on each step, who can claim exemption from withholding, other details, and privacy.

Step 2: Multiple Jobs or Spouse Works

Complete this step if you (1) hold more than one job at a time, or (2) are married filing jointly and your spouse also works. The correct amount of withholding depends on income earned from all of these jobs.

Do **only one** of the following.

(a) Reserved for future use.

(b) Use the Multiple Jobs Worksheet on page 3 and enter the result in Step 4(c) below; **or**

(c) If there are only two jobs total, you may check this box. Do the same on Form W-4 for the other job. This option is generally more accurate than (b) if pay at the lower paying job is more than half of the pay at the higher paying job. Otherwise, (b) is more accurate . . . . . ☐

TIP: If you have self-employment income, see page 2.

Complete Steps 3–4(b) on Form W-4 for only ONE of these jobs. Leave those steps blank for the other jobs. (Your withholding will be most accurate if you complete Steps 3–4(b) on the Form W-4 for the highest paying job.)

Step 3: Claim Dependent and Other Credits

If your total income will be $200,000 or less ($400,000 or less if married filing jointly):

Multiply the number of qualifying children under age 17 by $2,000 $ _____

Multiply the number of other dependents by $500 . . . . . $ _____

Add the amounts above for qualifying children and other dependents. You may add to this the amount of any other credits. Enter the total here . . . . . **3** $

Step 4 (optional): Other Adjustments

(a) Other income (not from jobs). If you want tax withheld for other income you expect this year that won't have withholding, enter the amount of other income here. This may include interest, dividends, and retirement income . . . . . **4(a)** $

(b) Deductions. If you expect to claim deductions other than the standard deduction and want to reduce your withholding, use the Deductions Worksheet on page 3 and enter the result here . . . . . **4(b)** $

(c) Extra withholding. Enter any additional tax you want withheld each **pay period** . . **4(c)** $

Step 5: Sign Here

Under penalties of perjury, I declare that this certificate, to the best of my knowledge and belief, is true, correct, and complete.

Employee's signature (This form is not valid unless you sign it.) **Date**

Employers Only

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

General Instructions

Section references are to the Internal Revenue Code.

Future Developments

For the latest information about developments related to Form W-4, such as legislation enacted after it was published, go to *www.irs.gov/FormW4*.

Purpose of Form

Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay. If too little is withheld, you will generally owe tax when you file your tax return and may owe a penalty. If too much is withheld, you will generally be due a refund. Complete a new Form W-4 when changes to your personal or financial situation would change the entries on the form. For more information on withholding and when you must furnish a new Form W-4, see Pub. 505, Tax Withholding and Estimated Tax.

Exemption from withholding. You may claim exemption from withholding for 2023 if you meet both of the following conditions: you had no federal income tax liability in 2022 **and** you expect to have no federal income tax liability in 2023. You had no federal income tax liability in 2022 if (1) your total tax on line 24 on your 2022 Form 1040 or 1040-SR is zero (or less than the sum of lines 27, 28, and 29), or (2) you were not required to file a return because your income was below the filing threshold for your correct filing status. If you claim exemption, you will have no income tax withheld from your paycheck and may owe taxes and penalties when you file your 2023 tax return. To claim exemption from withholding, certify that you meet both of the conditions above by writing "Exempt" on Form W-4 in the space below Step 4(c). Then, complete Steps 1(a), 1(b), and 5. Do not complete any other steps. You will need to submit a new Form W-4 by February 15, 2024.

Your privacy. If you have concerns with Step 2(c), you may choose Step 2(b); if you have concerns with Step 4(a), you may enter an additional amount you want withheld per pay period in Step 4(c).

Self-employment. Generally, you will owe both income and self-employment taxes on any self-employment income you receive separate from the wages you receive as an employee. If you want to pay income and self-employment taxes through withholding from your wages, you should enter the self-employment income on Step 4(a). Then compute your self-employment tax, divide that tax by the number of pay periods remaining in the year, and include that resulting amount per pay period on Step 4(c). You can also add half of the annual amount of self-employment tax to Step 4(b) as a deduction. To calculate self-employment tax, you generally multiply the self-employment income by 14.13% (this rate is a quick way to figure your self-employment tax and equals the sum of the 12.4% social security tax and the 2.9% Medicare tax multiplied by 0.9235). See Pub. 505 for more information, especially if the sum of self-employment income multiplied by 0.9235 and wages exceeds $160,200 for a given individual.

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

Specific Instructions

Step 1(c). Check your anticipated filing status. This will determine the standard deduction and tax rates used to compute your withholding.

Step 2. Use this step if you (1) have more than one job at the same time, or (2) are married filing jointly and you and your spouse both work.

If you (and your spouse) have a total of only two jobs, you may check the box in option **(c)**. The box must also be checked on the Form W-4 for the other job. If the box is checked, the standard deduction and tax brackets will be cut in half for each job to calculate withholding. This option is roughly accurate for jobs with similar pay; otherwise, more tax than necessary may be withheld, and this extra amount will be larger the greater the difference in pay is between the two jobs.

Multiple jobs. *Complete Steps 3 through 4(b) on only one Form W-4. Withholding will be most accurate if you do this on the Form W-4 for the highest paying job.*

Step 3. This step provides instructions for determining the amount of the child tax credit and the credit for other dependents that you may be able to claim when you file your tax return. To qualify for the child tax credit, the child must be under age 17 as of December 31, must be your dependent who generally lives with you for more than half the year, and must have the required social security number. You may be able to claim a credit for other dependents for whom a child tax credit can't be claimed, such as an older child or a qualifying relative. For additional eligibility requirements for these credits, see Pub. 501, Dependents, Standard Deduction, and Filing Information. You can also include **other tax credits** for which you are eligible in this step, such as the foreign tax credit and the education tax credits. To do so, add an estimate of the amount for the year to your credits for dependents and enter the total amount in Step 3. Including these credits will increase your paycheck and reduce the amount of any refund you may receive when you file your tax return.

Step 4 (optional).

Step 4(a). Enter in this step the total of your other estimated income for the year, if any. You shouldn't include income from any jobs or self-employment. If you complete Step 4(a), you likely won't have to make estimated tax payments for that income. If you prefer to pay estimated tax rather than having tax on other income withheld from your paycheck, see Form 1040-ES, Estimated Tax for Individuals.

Step 4(b). Enter in this step the amount from the Deductions Worksheet, line 5, if you expect to claim deductions other than the basic standard deduction on your 2023 tax return and want to reduce your withholding to account for these deductions. This includes both itemized deductions and other deductions such as for student loan interest and IRAs.

Step 4(c). Enter in this step any additional tax you want withheld from your pay **each pay period**, including any amounts from the Multiple Jobs Worksheet, line 4. Entering an amount here will reduce your paycheck and will either increase your refund or reduce any amount of tax that you owe.

Step 2(b)—Multiple Jobs Worksheet *(Keep for your records.)*

If you choose the option in Step 2(b) on Form W-4, complete this worksheet (which calculates the total extra tax for all jobs) on **only ONE** Form W-4. Withholding will be most accurate if you complete the worksheet and enter the result on the Form W-4 for the highest paying job. To be accurate, submit a new Form W-4 for all other jobs if you have not updated your withholding since 2019.

Note: If more than one job has annual wages of more than $120,000 or there are more than three jobs, see Pub. 505 for additional tables.

1 **Two jobs.** If you have two jobs or you're married filing jointly and you and your spouse each have one job, find the amount from the appropriate table on page 4. Using the "Higher Paying Job" row and the "Lower Paying Job" column, find the value at the intersection of the two household salaries and enter that value on line 1. Then, **skip** to line 3 . . . . . **1** $

2 **Three jobs.** If you and/or your spouse have three jobs at the same time, complete lines 2a, 2b, and 2c below. Otherwise, skip to line 3.

a Find the amount from the appropriate table on page 4 using the annual wages from the highest paying job in the "Higher Paying Job" row and the annual wages for your next highest paying job in the "Lower Paying Job" column. Find the value at the intersection of the two household salaries and enter that value on line 2a . . . . . **2a** $

b Add the annual wages of the two highest paying jobs from line 2a together and use the total as the wages in the "Higher Paying Job" row and use the annual wages for your third job in the "Lower Paying Job" column to find the amount from the appropriate table on page 4 and enter this amount on line 2b . . . . . **2b** $

c Add the amounts from lines 2a and 2b and enter the result on line 2c . . . . . **2c** $

3 Enter the number of pay periods per year for the highest paying job. For example, if that job pays weekly, enter 52; if it pays every other week, enter 26; if it pays monthly, enter 12, etc. **3**

4 **Divide** the annual amount on line 1 or line 2c by the number of pay periods on line 3. Enter this amount here and in **Step 4(c)** of Form W-4 for the highest paying job (along with any other additional amount you want withheld) . . . . . **4** $

Step 4(b)—Deductions Worksheet *(Keep for your records.)*

1 Enter an estimate of your 2023 itemized deductions (from Schedule A (Form 1040)). Such deductions may include qualifying home mortgage interest, charitable contributions, state and local taxes (up to $10,000), and medical expenses in excess of 7.5% of your income . . . . . **1** $

2 Enter:
- $27,700 if you're married filing jointly or a qualifying surviving spouse
- $20,800 if you're head of household
- $13,850 if you're single or married filing separately

. . . . . **2** $

3 If line 1 is greater than line 2, subtract line 2 from line 1 and enter the result here. If line 2 is greater than line 1, enter "-0-" . . . . . **3** $

4 Enter an estimate of your student loan interest, deductible IRA contributions, and certain other adjustments (from Part II of Schedule 1 (Form 1040)). See Pub. 505 for more information . . . . **4** $

5 **Add** lines 3 and 4. Enter the result here and in **Step 4(b)** of Form W-4 . . . . . **5** $

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

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

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

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

Married Filing Jointly or Qualifying Surviving Spouse

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	$0 - 9,999	$10,000 - 19,999	$20,000 - 29,999	$30,000 - 39,999	$40,000 - 49,999	$50,000 - 59,999	$60,000 - 69,999	$70,000 - 79,999	$80,000 - 89,999	$90,000 - 99,999	$100,000 - 109,999	$110,000 - 120,000
$0 - 9,999	$0	$0	$850	$850	$1,000	$1,020	$1,020	$1,020	$1,020	$1,020	$1,020	$1,870
$10,000 - 19,999	0	930	1,850	2,000	2,200	2,220	2,220	2,220	2,220	2,220	3,200	4,070
$20,000 - 29,999	850	1,850	2,920	3,120	3,320	3,340	3,340	3,340	3,340	4,320	5,320	6,190
$30,000 - 39,999	850	2,000	3,120	3,320	3,520	3,540	3,540	3,540	4,520	5,520	6,520	7,390
$40,000 - 49,999	1,000	2,200	3,320	3,520	3,720	3,740	3,740	4,720	5,720	6,720	7,720	8,590
$50,000 - 59,999	1,020	2,220	3,340	3,540	3,740	3,760	4,750	5,750	6,750	7,750	8,750	9,610
$60,000 - 69,999	1,020	2,220	3,340	3,540	3,740	4,750	5,750	6,750	7,750	8,750	9,750	10,610
$70,000 - 79,999	1,020	2,220	3,340	3,540	4,720	5,750	6,750	7,750	8,750	9,750	10,750	11,610
$80,000 - 99,999	1,020	2,220	4,170	5,370	6,570	7,600	8,600	9,600	10,600	11,600	12,600	13,460
$100,000 - 149,999	1,870	4,070	6,190	7,390	8,590	9,610	10,610	11,660	12,860	14,060	15,260	16,330
$150,000 - 239,999	2,040	4,440	6,760	8,160	9,560	10,780	11,980	13,180	14,380	15,580	16,780	17,850
$240,000 - 259,999	2,040	4,440	6,760	8,160	9,560	10,780	11,980	13,180	14,380	15,580	16,780	17,850
$260,000 - 279,999	2,040	4,440	6,760	8,160	9,560	10,780	11,980	13,180	14,380	15,580	16,780	18,140
$280,000 - 299,999	2,040	4,440	6,760	8,160	9,560	10,780	11,980	13,180	14,380	15,870	17,870	19,740
$300,000 - 319,999	2,040	4,440	6,760	8,160	9,560	10,780	11,980	13,470	15,470	17,470	19,470	21,340
$320,000 - 364,999	2,040	4,440	6,760	8,550	10,750	12,770	14,770	16,770	18,770	20,770	22,770	24,640
$365,000 - 524,999	2,970	6,470	9,890	12,390	14,890	17,220	19,520	21,820	24,120	26,420	28,720	30,880
$525,000 and over	3,140	6,840	10,460	13,160	15,860	18,390	20,890	23,390	25,890	28,390	30,890	33,250

Single or Married Filing Separately

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	$0 - 9,999	$10,000 - 19,999	$20,000 - 29,999	$30,000 - 39,999	$40,000 - 49,999	$50,000 - 59,999	$60,000 - 69,999	$70,000 - 79,999	$80,000 - 89,999	$90,000 - 99,999	$100,000 - 109,999	$110,000 - 120,000
$0 - 9,999	$310	$890	$1,020	$1,020	$1,020	$1,860	$1,870	$1,870	$1,870	$1,870	$2,030	$2,040
$10,000 - 19,999	890	1,630	1,750	1,750	2,600	3,600	3,600	3,600	3,600	3,760	3,960	3,970
$20,000 - 29,999	1,020	1,750	1,880	2,720	3,720	4,720	4,730	4,730	4,890	5,090	5,290	5,300
$30,000 - 39,999	1,020	1,750	2,720	3,720	4,720	5,720	5,730	5,890	6,090	6,290	6,490	6,500
$40,000 - 59,999	1,710	3,450	4,570	5,570	6,570	7,700	7,910	8,110	8,310	8,510	8,710	8,720
$60,000 - 79,999	1,870	3,600	4,730	5,860	7,060	8,260	8,460	8,660	8,860	9,060	9,260	9,280
$80,000 - 99,999	1,870	3,730	5,060	6,260	7,460	8,660	8,860	9,060	9,260	9,460	10,430	11,240
$100,000 - 124,999	2,040	3,970	5,300	6,500	7,700	8,900	9,110	9,610	10,610	11,610	12,610	13,430
$125,000 - 149,999	2,040	3,970	5,300	6,500	7,700	9,610	10,610	11,610	12,610	13,610	14,900	16,020
$150,000 - 174,999	2,040	3,970	5,610	7,610	9,610	11,610	12,610	13,750	15,050	16,350	17,650	18,770
$175,000 - 199,999	2,720	5,450	7,580	9,580	11,580	13,870	15,180	16,480	17,780	19,080	20,380	21,490
$200,000 - 249,999	2,900	5,930	8,360	10,660	12,960	15,260	16,570	17,870	19,170	20,470	21,770	22,880
$250,000 - 399,999	2,970	6,010	8,440	10,740	13,040	15,340	16,640	17,940	19,240	20,540	21,840	22,960
$400,000 - 449,999	2,970	6,010	8,440	10,740	13,040	15,340	16,640	17,940	19,240	20,540	21,840	22,960
$450,000 and over	3,140	6,380	9,010	11,510	14,010	16,510	18,010	19,510	21,010	22,510	24,010	25,330

Head of Household

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	$0 - 9,999	$10,000 - 19,999	$20,000 - 29,999	$30,000 - 39,999	$40,000 - 49,999	$50,000 - 59,999	$60,000 - 69,999	$70,000 - 79,999	$80,000 - 89,999	$90,000 - 99,999	$100,000 - 109,999	$110,000 - 120,000
$0 - 9,999	$0	$620	$860	$1,020	$1,020	$1,020	$1,020	$1,650	$1,870	$1,870	$1,890	$2,040
$10,000 - 19,999	620	1,630	2,060	2,220	2,220	2,220	2,850	3,850	4,070	4,090	4,290	4,440
$20,000 - 29,999	860	2,060	2,490	2,650	2,650	3,280	4,280	5,280	5,520	5,720	5,920	6,070
$30,000 - 39,999	1,020	2,220	2,650	2,810	3,440	4,440	5,440	6,460	6,880	7,080	7,280	7,430
$40,000 - 59,999	1,020	2,220	3,130	4,290	5,290	6,290	7,480	8,680	9,100	9,300	9,500	9,650
$60,000 - 79,999	1,500	3,700	5,130	6,290	7,480	8,680	9,880	11,080	11,500	11,700	11,900	12,050
$80,000 - 99,999	1,870	4,070	5,690	7,050	8,250	9,450	10,650	11,850	12,260	12,460	12,870	13,820
$100,000 - 124,999	2,040	4,440	6,070	7,430	8,630	9,830	11,030	12,230	13,190	14,190	15,190	16,150
$125,000 - 149,999	2,040	4,440	6,070	7,430	8,630	9,980	11,980	13,980	15,190	16,190	17,270	18,530
$150,000 - 174,999	2,040	4,440	6,070	7,980	9,980	11,980	13,980	15,980	17,420	18,720	20,020	21,280
$175,000 - 199,999	2,190	5,390	7,820	9,980	11,980	14,060	16,360	18,660	20,170	21,470	22,770	24,030
$200,000 - 249,999	2,720	6,190	8,920	11,380	13,680	15,980	18,280	20,580	22,090	23,390	24,690	25,950
$250,000 - 449,999	2,970	6,470	9,200	11,660	13,960	16,260	18,560	20,860	22,380	23,680	24,980	26,230
$450,000 and over	3,140	6,840	9,770	12,430	14,930	17,430	19,930	22,430	24,150	25,650	27,150	28,600

Cost Management Services

FRONTLINE HRO
effective strategies & customized coverage

Dear Employee,

Your company is participating in a federal program under the PATH Act to create jobs.

In order to meet the guidelines for this program, we are requesting your assistance in completing the following brief survey via telephone, web link or web link QR code. All information you provide will remain confidential, and will not impact the hiring process.

Any information you provide is confidential and will be reviewed in strict confidence with the Department of Labor to determine eligibility for the available job initiation programs.

Please select one of the following methods to complete this process-

Web Screening: **https://wotc.irecruit-us.com/admin.php?wotcID=frontlineHRO**

Smart Phone Web Screening:

SCAN ME

Call Center #: 866-597-6917

Your time and cooperation with this effort is greatly appreciated.

Thank you!

Complete Top Portion Only & Sign/Date Bottom

Form **8850** (Rev. March 2016)

Department of the Treasury
Internal Revenue Service

Pre-Screening Notice and Certification Request for the Work Opportunity Credit

► **Information about Form 8850 and its separate instructions is at *www.irs.gov/form8850.***

OMB No. 1545-1500

Job applicant: Fill in the lines below and check any boxes that apply. Complete only this side.

Your name _____ Social security number ► _____

Street address where you live _____

City or town, state, and ZIP code _____

County _____ Telephone number _____

Enter your date of birth (month, day, year) _____

1 ☐ Check here if you received a conditional certification from the state workforce agency (SWA) or a participating local agency for the work opportunity credit.

2 ☐ Check here if **any** of the following statements apply to you.

- I am a member of a family that has received assistance from Temporary Assistance for Needy Families (TANF) for any 9 months during the past 18 months.
- I am a veteran and a member of a family that received Supplemental Nutrition Assistance Program (SNAP) benefits (food stamps) for at least a 3-month period during the past 15 months.
- I was referred here by a rehabilitation agency approved by the state, an employment network under the Ticket to Work program, or the Department of Veterans Affairs.
- I am at least age 18 but **not** age 40 or older and I am a member of a family that:
  a. Received SNAP benefits (food stamps) for the past 6 months; **or**
  b. Received SNAP benefits (food stamps) for at least 3 of the past 5 months, **but** is no longer eligible to receive them.
- During the past year, I was convicted of a felony or released from prison for a felony.
- I received supplemental security income (SSI) benefits for any month ending during the past 60 days.
- I am a veteran and I was unemployed for a period or periods totaling at least 4 weeks but less than 6 months during the past year.

3 ☐ Check here if you are a veteran and you were unemployed for a period or periods totaling at least 6 months during the past year.

4 ☐ Check here if you are a veteran entitled to compensation for a service-connected disability and you were discharged or released from active duty in the U.S. Armed Forces during the past year.

5 ☐ Check here if you are a veteran entitled to compensation for a service-connected disability and you were unemployed for a period or periods totaling at least 6 months during the past year.

6 ☐ Check here if you are a member of a family that:

- Received TANF payments for at least the past 18 months; **or**
- Received TANF payments for any 18 months beginning after August 5, 1997, **and** the earliest 18-month period beginning after August 5, 1997, ended during the past 2 years; **or**
- Stopped being eligible for TANF payments during the past 2 years because federal or state law limited the maximum time those payments could be made.

7 ☐ Check here if you are in a period of unemployment that is at least 27 consecutive weeks and for all or part of that period you received unemployment compensation.

Signature—All Applicants Must Sign

Under penalties of perjury, I declare that I gave the above information to the employer on or before the day I was offered a job, and it is, to the best of my knowledge, true, correct, and complete.

SIGN HERE

Job applicant's signature ► **Date**

Cost Management Services

FRONTLINE HRO
effective strategies & customized coverage

Dear New Employee:
Your employer is participating in a federal program to initiate jobs.
In order to complete the requirements, please complete the survey below:

Signature: _____ Date: ____/____/_____ Social Security: #_____-____-_____

Print Name: _____ Date of Birth: ____/____/_____ How old are you?:_____

Have you worked for this employer before? **YES** ☐ **NO** ☐ If **Yes**, last date of employment: ____/____/_____

PLEASE ANSWER YES OR NO TO THE FOLLOWING QUESTIONS:
(Please also complete the top and sign the bottom of the attached 8850 form. Thank you!)

1. In the **past 6 months,** have you or family member received **SNAP / Food Stamps**? **YES** ☐ **NO** ☐
   If **YES,** please give name of primary recipient & City/State: _____
2. In the **last 18 months,** have you received **TANF** (Temporary Assistance for Needy Families)? **YES** ☐ **NO** ☐
   If **YES**, please give name of primary recipient & City/State: _____
3. **Are you a VETERAN of the U.S. Armed Forces? YES** ☐ **NO** ☐ **(IF NO, Please GO to Question #4.)**
   - *Have you been unemployed a **combined period of (6) months during the past year?*** **YES** ☐ **NO** ☐
   - *Have you been unemployed for a **combined period of (4) weeks but less than (6) months during the past year?*** **YES** ☐ **NO** ☐
   - *Were you discharged or released from active duty within the past year?* **YES** ☐ **NO** ☐
   - *Are you entitled to compensation for a service-connected disability?* **YES** ☐ **NO** ☐
   - *Are you a member of a family that received SNAP benefits for **at least 3 months during the past 15 months before you were hired**?* **YES** ☐ **NO** ☐

   If **YES**, please give name of primary recipient & City/State: _____
4. In the **past 60 days**, did you receive Supplemental Security Income (**SSI**) benefits? **YES** ☐ **NO** ☐
5. In the **last year**, were you convicted of a felony or released from prison after a felony conviction? **YES** ☐ **NO** ☐
   - If **Yes,** enter the date of conviction: ____/____/_____ & date of release: ____/____/_____
   - Was this a federal ☐ or a state ☐ conviction?
6. Are you being referred by an agency for employees with disabilities? (Must be a Vocational Rehabilitation Agency)
   - **YES** ☐ **NO** ☐
   - Are you being referred by Social Security's Ticket to Work Program for employees with disabilities? **YES** ☐ **NO** ☐
   - Are you being referred by the Department of Veteran Affairs? **YES** ☐ **NO** ☐
7. **Have you received Unemployment Compensation for more than 26 consecutive weeks? YES** ☐ **NO** ☐

Starting Hourly Wage: $_____ **Start Date:** ____/____/_____

CMS is responsible for administering this program for your employer, and is an independent organization. All information disclosed by yourself, therefore, will be handled independently by your employer. The information you provide is confidential and will be used only by CMS in strict confidence with the Department of Labor to determine your eligibility for the program. Thank you for your time and effort.

Employment Development Department
State of California

Clear Form

EMPLOYEE'S WITHHOLDING ALLOWANCE CERTIFICATE

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

Enter Personal Information	
First, Middle, Last Name	Social Security Number
Address City, State, and ZIP Code	Filing Status ☐ SINGLE or MARRIED (with two or more incomes) ☐ MARRIED (one income) ☐ HEAD OF HOUSEHOLD

1. Total Number of Allowances you're claiming (Use Worksheet A for regular withholding allowances. Use other worksheets on the following pages as applicable, Worksheet A+B). _____

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

Exemption from Withholding

3. I claim exemption from withholding for 2020, and I certify I meet both of the conditions for exemption. ☐ Write "Exempt" here
   OR

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

Under the penalties of perjury, I certify that the number of withholding allowances claimed on this certificate does not exceed the number to which I am entitled or, if claiming exemption from withholding, that I am entitled to claim the exempt status.

Employee's Signature _____ Date _____

Employer's Section: Employer's Name and Address	California Employer Payroll Tax Account Number

PURPOSE: This certificate, DE 4, is for **California Personal Income Tax (PIT) withholding** purposes only. The DE 4 is used to compute the amount of taxes to be withheld from your wages, by your employer, to accurately reflect your state tax withholding obligation.

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

If you do not provide your employer with a withholding certificate, the employer must use Single with Zero withholding allowance.

CHECK YOUR WITHHOLDING: After your DE 4 takes effect, compare the state income tax withheld with your estimated total annual tax. For state withholding, use the worksheets on this form.

EXEMPTION FROM WITHHOLDING: If you wish to claim exempt, complete the federal Form W-4 and the state DE 4. You may claim exempt from withholding California income tax if you meet both of the following conditions for exemption:

1. You did not owe any federal/state income tax last year, and
2. You do not expect to owe any federal/state income tax this year. The exemption is good for one year.

If you continue to qualify for the exempt filing status, a new DE 4 designating EXEMPT must be submitted by February 15 each year to continue your exemption. If you are not having federal/state income tax withheld this year but expect to have a tax liability next year, you are required to give your employer a new DE 4 by December 1.

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

(i) your spouse is a member of the armed forces present in California in compliance with military orders;

(ii) you are present in California solely to be with your spouse; and

(iii) you maintain your domicile in another state.

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

The ***California Employer's Guide*** **(DE 44) (PDF, 2.4 MB)** (edd.ca.gov/pdf_pub_ctr/de44.pdf) provides the income tax withholding tables. This publication may be found by visiting **Forms and Publications** (edd.ca.gov/Payroll_Taxes/Forms_and_Publications.htm). To assist you in calculating your tax liability, please visit the **Franchise Tax Board (FTB)** (ftb.ca.gov).

If you need information on your last *California Resident Income Tax Return* (FTB Form 540), visit the Franchise Tax Board (FTB) (ftb.ca.gov).

NOTIFICATION: The burden of proof rests with the employee to show the correct California income tax withholding. Pursuant to section 4340-1(e) of **Title 22, California Code of Regulations (CCR)**, the FTB or the EDD may, by special direction in writing, require an employer to submit a Form W-4 or DE 4 when such forms are necessary for the administration of the withholding tax programs.

PENALTY: You may be fined $500 if you file, with no reasonable basis, a DE 4 that results in less tax being withheld than is properly allowable. In addition, criminal penalties apply for willfully supplying false or fraudulent information or failing to supply information requiring an increase in withholding. This is provided by section 13101 of the **California Unemployment Insurance Code** and section 19176 of the **Revenue and Taxation Code**.

INSTRUCTIONS — 1 — ALLOWANCES*

When determining your withholding allowances, you must consider your personal situation:
— Do you claim allowances for dependents or blindness?
— Will you itemize your deductions?
— Do you have more than one income coming into the household?

TWO-EARNERS/MULTIPLE INCOMES: When earnings are derived from more than one source, under-withholding may occur. If you have a working spouse or more than one job, it is best to check the box "SINGLE or MARRIED (with two or more incomes)." Figure the total number of allowances you are entitled to claim on all jobs using only one DE 4 form. Claim allowances with **one** employer.

Do **not** claim the same allowances with more than one employer. Your withholding will usually be most accurate when all allowances are claimed on the DE 4 filed for the highest paying job and zero allowances are claimed for the others.

MARRIED BUT NOT LIVING WITH YOUR SPOUSE: You may check the "Head of Household" marital status box if you meet all of the following tests:
(1) Your spouse will not live with you **at any time** during the year;
(2) You will furnish over half of the cost of maintaining a home for the entire year for yourself and your child or stepchild who qualifies as your dependent; **and**
(3) You will file a separate return for the year.

HEAD OF HOUSEHOLD: To qualify, you must be unmarried or legally separated from your spouse and pay more than 50% of the costs of maintaining a home for the **entire** year for yourself and your dependent(s) or other qualifying individuals. Cost of maintaining the home includes such items as rent, property insurance, property taxes, mortgage interest, repairs, utilities, and cost of food. It does not include the individual's personal expenses or any amount which represents value of services performed by a member of the household of the taxpayer.

WORKSHEET A **REGULAR WITHHOLDING ALLOWANCES**

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

INSTRUCTIONS — 2 — (OPTIONAL) ADDITIONAL WITHHOLDING ALLOWANCES

If you expect to itemize deductions on your California income tax return, you can claim additional withholding allowances. Use Worksheet B to determine whether your expected estimated deductions may entitle you to claim **one or more additional** withholding allowances. Use last year's FTB Form 540 as a model to calculate this year's withholding amounts.

Do not include deferred compensation, qualified pension payments, or flexible benefits, etc., that are deducted from your gross pay but are not taxed on this worksheet.

You may reduce the amount of tax withheld from your wages by claiming one additional withholding allowance for each $1,000, or fraction of $1,000, by which you expect your estimated deductions for the year to exceed your allowable standard deduction.

WORKSHEET B **ESTIMATED DEDUCTIONS**

Use this worksheet **only** if you plan to itemize deductions, claim certain adjustments to income, or have a large amount of nonwage income not subject to withholding.

1.	Enter an estimate of your itemized deductions for California taxes for this tax year as listed in the schedules in the FTB Form 540	1.	_____
2.	Enter $9,074 if married filing joint with two or more allowances, unmarried head of household, or qualifying widow(er) with dependent(s) or $4,537 if single or married filing separately, dual income married, or married with multiple employers	– 2.	_____
3.	Subtract line 2 from line 1, enter difference	= 3.	_____
4.	Enter an estimate of your adjustments to income (alimony payments, IRA deposits)	+ 4.	_____
5.	Add line 4 to line 3, enter sum	= 5.	_____
6.	Enter an estimate of your nonwage income (dividends, interest income, alimony receipts)	– 6.	_____
7.	If line 5 is greater than line 6 (if less, see below [go to line 9]); Subtract line 6 from line 5, enter difference	= 7.	_____
8.	Divide the amount on line 7 by $1,000, round any fraction to the nearest whole number	8.	_____
	Add this number to Line F of Worksheet A and enter it on line 1 of the DE 4. Complete Worksheet C, if needed, otherwise **stop here**.		
9.	If line 6 is greater than line 5; Enter amount from line 6 (nonwage income)	9.	_____
10.	Enter amount from line 5 (deductions)	10.	_____
11.	Subtract line 10 from line 9, enter difference	11.	_____
	Complete Worksheet C		

*Wages paid to registered domestic partners will be treated the same for state income tax purposes as wages paid to spouses for California PIT withholding and PIT wages. This law does not impact federal income tax law. A registered domestic partner means an individual partner in a domestic partner relationship within the meaning of section 297 of the Family Code. For more information, please call our Taxpayer Assistance Center at 1-888-745-3886.

WORKSHEET C **ADDITIONAL TAX WITHHOLDING AND ESTIMATED TAX**

1.	Enter estimate of total wages for tax year 2020.	1.
2.	Enter estimate of nonwage income (line 6 of Worksheet B).	2.
3.	Add line 1 and line 2. Enter sum.	3.
4.	Enter itemized deductions or standard deduction (line 1 or 2 of Worksheet B, whichever is largest).	4.
5.	Enter adjustments to income (line 4 of Worksheet B).	5.
6.	Add line 4 and line 5. Enter sum.	6.
7.	Subtract line 6 from line 3. Enter difference.	7.
8.	Figure your tax liability for the amount on line 7 by using the 2020 tax rate schedules below.	8.
9.	Enter personal exemptions (line F of Worksheet A x $134.20).	9.
10.	Subtract line 9 from line 8. Enter difference.	10.
11.	Enter any tax credits. (See FTB Form 540).	11.
12.	Subtract line 11 from line 10. Enter difference. This is your total tax liability.	12.
13.	Calculate the tax withheld and estimated to be withheld during 2020. Contact your employer to request the amount that will be withheld on your wages based on the marital status and number of withholding allowances you will claim for 2020. Multiply the estimated amount to be withheld by the number of pay periods left in the year. Add the total to the amount already withheld for 2020.	13.
14.	Subtract line 13 from line 12. Enter difference. If this is less than zero, you do not need to have additional taxes withheld.	14.
15.	Divide line 14 by the number of pay periods remaining in the year. Enter this figure on line 2 of the DE 4.	15.

NOTE: Your employer is not required to withhold the additional amount requested on line 2 of your DE 4. If your employer does not agree to withhold the additional amount, you may increase your withholdings as much as possible by using the "single" status with "zero" allowances. If the amount withheld still results in an underpayment of state income taxes, you may need to file quarterly estimates on Form 540-ES with the FTB to avoid a penalty.

THESE TABLES ARE FOR CALCULATING WORKSHEET C AND FOR 2020 ONLY

SINGLE PERSONS, DUAL INCOME MARRIED WITH MULTIPLE EMPLOYERS

IF THE TAXABLE INCOME IS		COMPUTED TAX IS		
OVER	BUT NOT OVER	OF AMOUNT OVER...		PLUS
$0	$8,809	1.100%	$0	$0.00
$8,809	$20,883	2.200%	$8,809	$96.90
$20,883	$32,960	4.400%	$20,883	$362.53
$32,960	$45,753	6.600%	$32,960	$893.92
$45,753	$57,824	8.800%	$45,753	$1,738.26
$57,824	$295,373	10.230%	$57,824	$2,800.51
$295,373	$354,445	11.330%	$295,373	$27,101.77
$354,445	$590,742	12.430%	$354,445	$33,794.63
$590,742	$1,000,000	13.530%	$590,742	$63,166.35
$1,000,000	and over	14.630%	$1,000,000	$118,538.96

UNMARRIED HEAD OF HOUSEHOLD

IF THE TAXABLE INCOME IS		COMPUTED TAX IS		
OVER	BUT NOT OVER	OF AMOUNT OVER...		PLUS
$0	$17,629	1.100%	$0	$0.00
$17,629	$41,768	2.200%	$17,629	$193.92
$41,768	$53,843	4.400%	$41,768	$724.98
$53,843	$66,636	6.600%	$53,843	$1,256.28
$66,636	$78,710	8.800%	$66,636	$2,100.62
$78,710	$401,705	10.230%	$78,710	$3,163.13
$401,705	$482,047	11.330%	$401,705	$36,205.52
$482,047	$803,410	12.430%	$482,047	$45,308.27
$803,410	$1,000,000	13.530%	$803,410	$85,253.69
$1,000,000	and over	14.630%	$1,000,000	$111,852.32

MARRIED PERSONS

IF THE TAXABLE INCOME IS		COMPUTED TAX IS		
OVER	BUT NOT OVER	OF AMOUNT OVER...		PLUS
$0	$17,618	1.100%	$0	$0.00
$17,618	$41,766	2.200%	$17,618	$193.80
$41,766	$65,920	4.400%	$41,766	$725.06
$65,920	$91,506	6.600%	$65,920	$1,787.84
$91,506	$115,648	8.800%	$91,506	$3,476.52
$115,648	$590,746	10.230%	$115,648	$5,601.02
$590,746	$708,890	11.330%	$590,746	$54,203.55
$708,890	$1,000,000	12.430%	$708,890	$67,589.27
$1,000,000	$1,181,484	13.530%	$1,000,000	$103,774.24
$1,181,484	and over	14.630%	$1,181,484	$128,329.03

If you need information on your last California Resident Income Tax Return, FTB Form 540, visit **Franchise Tax Board (FTB)** (ftb.ca.gov).

The DE 4 information is collected for purposes of administering the PIT law and under the authority of Title 22, CCR, section 4340-1, and the California Revenue and Taxation Code, including section 18624. The Information Practices Act of 1977 requires that individuals be notified of how information they provide may be used. Further information is contained in the instructions that came with your last California resident income tax return.

FAMILY CARE & MEDICAL LEAVE & PREGNANCY DISABILITY LEAVE

DFEH

THE DEPARTMENT OF FAIR EMPLOYMENT AND HOUSING

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 AND HUMAN TRAFFICKING.

Under the California Family Rights Act of 1993 you may have a right to a family care or medical leave for the birth, adoption, or foster care placement of your child or for your own serious health condition or that of your child, parent or spouse. California law also prohibits employers from denying or interfering with requests for Pregnancy Disability Leave.

Under the California Family Rights Act of 1993 (CFRA), if you have more than 12 months of service with us and have worked at least 1,250 hours in the 12-month period before the date you want to begin your leave, and if we employ 50 or more employees at your worksite or within 75 miles of your worksite, you may have a right to a family care or medical leave (CFRA leave). This leave may be up to 12 workweeks in a 12-month period for the birth, adoption, or foster care placement of your child or for your own serious health condition or that of your child, parent or spouse. If we employ less than 50 employees at your worksite or within 75 miles of your worksite, but at least 20 employees at your worksite or within 75 miles of your worksite, you may have a right to a family care leave for the birth, adoption, or foster care placement of your child under the New Parent Leave Act (NPLA). Similar to CFRA leave, the NPLA leave may be up to 12 workweeks in a 12-month period. While the law provides only unpaid leave, employees may choose or employers may require use of accrued paid leave while taking CFRA leave under certain circumstances and employees may choose to use accrued paid leave while taking NPLA leave.

Even if you are not eligible for CFRA or NPLA leave, if you are disabled by pregnancy, childbirth or a related medical condition, you are entitled to take a pregnancy disability leave of up to four months, depending on your period(s) of actual disability. If you are CFRA or NPLA-eligible, you have certain rights to take BOTH a pregnancy disability leave and a CFRA or NPLA leave for reason of the birth of your child. Both leaves contain a guarantee of reinstatement-for pregnancy disability it is to the same position and for CFRA or NPLA it is to the same or a comparable position-at the end of the leave, subject to any defense allowed under the law.

If possible, you must provide at least 30 days' advance notice for foreseeable events (such as the expected birth of a child or a planned medical treatment for yourself or of a family member). For events that are unforeseeable, we need you to notify us, at least verbally, as soon as you learn of the need for the leave. Failure to comply with these notice rules is grounds for, and may result in, deferral of the requested leave until you comply with this notice policy.

We may require certification from your health care provider before allowing you a leave for pregnancy disability or for your own serious health condition. We also may require certification from the health care provider of your child, parent or spouse, who has a serious health condition, before allowing you a leave to take care of that family member. When medically necessary, leave may be taken on an intermittent or reduced work schedule.

If you are taking a leave for the birth, adoption, or foster care placement of a child, the basic minimum duration of the leave is two weeks, and you must conclude the leave within one year of the birth or placement for adoption or foster care.

Taking a family care or pregnancy disability leave may impact certain of your benefits and your seniority date. If you want more information regarding your eligibility for a leave and/or the impact of the leave on your seniority and benefits, please contact DFEH.

To schedule an appointment, contact the Communication Center below.

If you have a disability that requires a reasonable accommodation, the DFEH can assist you by scribing your intake by phone or, for individuals who are Deaf or Hard of Hearing or have speech disabilities, through the California Relay Service (711), or you can contact us below.

CONTACT US

Toll Free: (800) 884-1684
TTY: (800) 700-2320
contact.center@dfeh.ca.gov
www.dfeh.ca.gov

DFEH-100-21ENG / December 2019

WHAT DOES "TRANSGENDER" MEAN?

Transgender is a term used to describe people whose gender identity differs from the sex they were assigned at birth. Gender expression is defined by the law to mean a "person's gender-related appearance and behavior whether or not stereotypically associated with the person's assigned sex at birth." Gender identity and gender expression are protected characteristics under the Fair Employment and Housing Act. That means that employers may not discriminate against someone because they identify as transgender or gender non-conforming. This includes the perception that someone is transgender or gender non-conforming.

WHAT IS A GENDER TRANSITION?

1. "Social transition" involves a process of socially aligning one's gender with the internal sense of self (e.g., changes in name and pronoun, bathroom facility usage, participation in activities like sports teams).

2. "Physical transition" refers to medical treatments an individual may undergo to physically align their body with internal sense of self (e.g., hormone therapies or surgical procedures).

A person does not need to complete any particular step in a gender transition in order to be protected by the law. An employer may not condition its treatment or accommodation of a transitioning employee upon completion of a particular step in a gender transition.

FAQ FOR EMPLOYERS

▪ What is an employer allowed to ask?

Employers may ask about an employee's employment history, and may ask for personal references, in addition to other non-discriminatory questions. An interviewer should not ask questions designed to detect a person's gender identity, including asking about their marital status, spouse's name, or relation of household members to one another. Employers should not ask questions about a person's body or whether they plan to have surgery.

▪ How do employers implement dress codes and grooming standards?

An employer who requires a dress code must enforce it in a non-discriminatory manner. This means that, unless an employer can demonstrate business necessity, each employee must be allowed to dress in accordance with their gender identity and gender expression. Transgender or gender non-conforming employees may not be held to any different standard of dress or grooming than any other employee.

▪ What are the obligations of employers when it comes to bathrooms, showers, and locker rooms?

All employees have a right to safe and appropriate restroom and locker room facilities. This includes the right to use a restroom or locker room that corresponds to the employee's gender identity, regardless of the employee's assigned sex at birth. In addition, where possible, an employer should provide an easily accessible unisex single stall bathroom for use by any employee who desires increased privacy, regardless of the underlying reason. Use of a unisex single stall restroom should always be a matter of choice. No employee should be forced to use one either as a matter of policy or due to harassment in a gender-appropriate facility. Unless exempted by other provisions of state law, all single-user toilet facilities in any business establishment, place of public accommodation, or state or local government agency must be identified as all-gender toilet facilities.

FILING A COMPLAINT

If you believe you are a victim of discrimination you may, within three years* of the discrimination, file a complaint of discrimination by contacting DFEH.

To schedule an appointment, contact the Communication Center below.

If you have a disability that requires a reasonable accommodation, the DFEH can assist you by scribing your intake by phone or, for individuals who are Deaf or Hard of Hearing or have speech disabilities, through the California Relay Service (711), or you can contact us below.

CONTACT US

Toll Free: (800) 884-1684
TTY: (800) 700-2320
contact.center@dfeh.ca.gov
www.dfeh.ca.gov

* Effective 1/1/2020.

DFEH

THE DEPARTMENT OF FAIR EMPLOYMENT AND HOUSING

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 AND HUMAN TRAFFICKING.

CALIFORNIA LAW PROHIBITS WORKPLACE DISCRIMINATION & HARASSMENT

The California Department of Fair Employment and Housing (DFEH) enforces laws that protect you from illegal discrimination and harrasment in employment based on your actual or perceived:

- ANCESTRY
- AGE (40 and above)
- COLOR
- DISABILITY (physical, mental, HIV and AIDS)
- GENETIC INFORMATION
- GENDER IDENTITY, GENDER EXPRESSION
- MARITAL STATUS
- MEDICAL CONDITION (genetic characteristics, cancer or a record or history of cancer)
- MILITARY OR VETERAN STATUS
- NATIONAL ORIGIN (includes language use and possession of a driver's license issued to persons unable to prove their presence in the United States is authorized under federal law)
- RACE (including, but not limited to, hair texture and protective hairstyles. Protective hairstyles includes, but is not limited to, such hairstyles as braids, locks, and twists)
- RELIGION (includes religious dress and grooming practices)
- SEX/GENDER (includes pregnancy, childbirth, breastfeeding and/or related medical conditions)
- SEXUAL ORIENTATION

CALIFORNIA LAW PROHIBITS WORKPLACE DISCRIMINATION & HARASSMENT

DFEH

THE CALIFORNIA FAIR EMPLOYMENT AND HOUSING ACT (GOVERNMENT CODE SECTIONS 12900 THROUGH 12996) AND ITS IMPLEMENTING REGULATIONS (CALIFORNIA CODE OF REGULATIONS, TITLE 2, SECTIONS 11000 THROUGH 11141):

1. Prohibit harassment of employees, applicants, unpaid interns, volunteers, and independent contractors by any persons and require employers to take all reasonable steps to prevent harassment. This includes a prohibition against sexual harassment, gender harassment, harassment based on pregnancy, childbirth, breastfeeding and/or related medical conditions, as well as harassment based on all other characteristics listed above.

2. Require that all employers provide information to each of their employees on the nature, illegality, and legal remedies that apply to sexual harassment. Employers may either develop their own publications, which must meet standards set forth in California Government Code section 12950, or use material from DFEH.

3. Require employers with 5 or more employees and all public entities to provide training for all employees regarding the prevention of sexual harassment, including harassment based on gender identity, gender expression, and sexual orientation.

4. Prohibit employers from limiting or prohibiting the use of any language in any workplace unless justified by business necessity. The employer must notify employees of the language restriction and consequences for violation. Also prohibits employers from discriminating against an applicant or employee because they possess a driver's license issued to a person who is unable to prove that their presence in the United States is authorized under federal law.

5. Require employers to reasonably accommodate an employee, unpaid intern, or job applicant's religious beliefs and practices, including the wearing or carrying of religious clothing, jewelry or artifacts, and hair styles, facial hair, or body hair, which are part of an individual's observance of their religious beliefs.

6. Require employers to reasonably accommodate employees or job applicants with disabilities to enable them to perform the essential functions of a job.

7. Permit job applicants, unpaid interns, volunteers, and employees to file complaints with DFEH against an employer, employment agency, or labor union that fails to grant equal employment as required by law.

8. Prohibit discrimination against any job applicant, unpaid intern, or employee in hiring, promotions, assignments, termination, or any term, condition, or privilege of employment.

9. Require employers, employment agencies, and unions to preserve applications, personnel records, and employment referral records for a minimum of two years.

10. Require employers to provide leaves of up to four months to employees disabled because of pregnancy, childbirth, or a related medical condition.

11. Require an employer to provide reasonable accommodations requested by an employee, on the advice of their health care provider, related to their pregnancy, childbirth, or a related medical condition.

12. Require employers of 20 or more persons to allow eligible employees to take up to 12 weeks leave in a 12-month period for the birth of a child or the placement of a child for adoption or foster care; also require employers of 50 or more persons to allow eligible employees to take up to 12 weeks leave in a 12-month period for an employee's own serious health condition or to care for a parent, spouse, or child with a serious health condition.

13. Require employment agencies to serve all applicants equally, refuse discriminatory job orders, and prohibit employers and employment agencies from making discriminatory pre-hiring inquiries or publishing help-wanted advertisements that express a discriminatory hiring preference.

14. Prohibit unions from discriminating in member admissions or dispatching members to jobs.

15. Prohibit retaliation against a person who opposes, reports, or assists another person to oppose unlawful discrimination.

FILING A COMPLAINT

The law provides for remedies for individuals who experience prohibited discrimination or harassment in the workplace. These remedies include hiring, front pay, back pay, promotion, reinstatement, cease-and-desist orders, expert witness fees, reasonable attorney's fees and costs, punitive damages, and emotional distress damages.

Job applicants, unpaid interns, and employees: If you believe you have experienced discrimination or harassment you may file a complaint with DFEH. Independent contractors and volunteers: If you believe you have been harassed, you may file a complaint with DFEH.

Complaints must be filed within three years* of the last act of discrimination/harassment. For victims who are under the age of eighteen, not later than three years after the last act of discrimination/harassment or one year after the victim's eighteenth birthday, whichever is later.

To schedule an appointment, contact the Communication Center below.

If you have a disability that requires a reasonable accommodation, the DFEH can assist you by scribing your intake by phone or, for individuals who are Deaf or Hard of Hearing or have speech disabilities, through the California Relay Service (711), or you can contact us below.

DFEH is committed to providing access to our materials in an alternative format as a reasonable accommodation for people with disabilities when requested.

Government Code section 12950 and California Code of Regulations, title 2, section 11013, require all employers to post this document. It must be conspicuously posted in hiring offices, on employee bulletin boards, in employment agency waiting rooms, union halls, and other places employees gather. Any employer whose workforce at any facility or establishment consists of more than 10% of non-English speaking persons must also post this notice in the appropriate language or languages.

CONTACT US

Toll Free: (800) 884-1684
TTY: (800) 700-2320
contact.center@dfeh.ca.gov
www.dfeh.ca.gov

* Effective 1/1/2020.

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: State National under master Policy of Frontline HRO
Address: 1775 Parker Rd. Building C. | Suite 210 Conyers, GA 30094
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.

About California Paid Family Leave

For many working Californians, finding time to be with a loved one when they need it most can be difficult. California's Paid Family Leave program was created for those moments that matter – when you are bonding with a new child or caring for a seriously ill family member.

Fast Facts About California Paid Family Leave

- Provides partial wage replacement benefits to bond with a new child (either by birth, adoption, or foster care placement) or to care for a seriously ill family member (child, parent, parent-in-law, grandparent, grandchild, sibling, spouse, or registered domestic partner).
- Doesn't have to be taken all at once.
- Provides approximately 60 to 70 percent of your salary during your leave.
- Funded through your State Disability Insurance tax withholding, so you are most likely eligible if you've paid into State Disability Insurance (noted as "CASDI" on paystubs) or a qualifying voluntary plan in the past 5 to 18 months.
- To bond with a new child, leave can be taken anytime within the first 12 months of a child entering your family.
- Citizenship and immigration status do not affect eligibility.

CALIFORNIA
PAID FAMILY LEAVE
moments matter.

Paid Family Leave:
Giving Californians the benefits they need to be there for the moments that matter.

English	1-877-238-4373
Spanish	1-877-379-3819
Cantonese	1-866-692-5595
Vietnamese	1-866-692-5596
Armenian	1-866-627-1567
Punjabi	1-866-627-1568
Tagalog	1-866-627-1569
TTY	1-800-445-1312

Individuals can also visit a Paid Family Leave or Disability Insurance office to obtain claim forms, receive information, or speak to a representative.

Visit a **State Disability Insurance office (edd.ca.gov/Disability/Contact_SDI.htm)** near you.

EDD Employment Development Department
State of California

For more information, visit:
CaliforniaPaidFamilyLeave.com

CALIFORNIA PAID FAMILY LEAVE

Helping Californians be present for the moments that matter.

Do I Qualify For California Paid Family Leave?

To qualify for Paid Family Leave benefits, **you must meet** the following requirements:

- Need to take time off from work to care for a seriously ill family member or to bond with a new child.
- Be covered by State Disability Insurance (or a voluntary plan in lieu of State Disability Insurance).
- Have earned at least $300 in the past 5 to 18 months.
- Submit your claim no later than 41 days after you begin your family leave. Do not file before your first day of leave.

If required by your employer, you must use up to two weeks of unused vacation leave or paid time off. Check with your human resources department to confirm your employer's requirements.

How Are Benefit Amounts Calculated?

California Paid Family Leave provides approximately 60 to 70 percent of your weekly salary (from $50 up to $1,300 weekly).

The benefit amount is calculated from your highest quarterly earnings over the past 5 to 18 months, before the start of your claim. The Employment Development Department (EDD) has an online calculator that can help you estimate your weekly benefit amount. Visit the **Disability Insurance and Paid Family Leave Calculator (edd.ca.gov/PFL_Calculator)** to estimate your benefit.

If you are found eligible to receive benefits, you have an option on how you receive your benefit payments: by the EDD Debit Card℠ through Bank of America or by check, mailed from the EDD.

Does Paid Family Leave Provide Job Protection?

California Paid Family Leave does not provide job protection or a right to return to work.

However, job protection may be provided under other laws such as the federal Family and Medical Leave Act, the California Family Rights Act, or the New Parent Leave Act (if you qualify).

Notify your employer of your plan to take leave and the reason for taking leave according to your company's policy.

How Do I Apply For Benefits?

Apply for Paid Family Leave benefits by visiting **SDI Online (edd.ca.gov/SDI_Online)**.

You may also apply using a paper form. Visit **EDD Forms and Publications (edd.ca.gov/Forms)** to request a *Claim for Paid Family Leave (PFL) Benefits* (DE 2501F) form.

For caregiving claims, you must provide medical certification showing that the care recipient has a serious health condition and requires your care. This needs to be completed by the care recipient's physician/practitioner. Information about the care recipient and their signature are also required.

For bonding claims, you must provide documentation showing proof of relationship between you and the child (e.g., a copy of the child's birth certificate, adoptive placement agreement, or foster care placement record).

If you are currently receiving pregnancy-related Disability Insurance benefits, it is not necessary to request a Paid Family Leave claim form. The form to file for bonding will be sent through your SDI Online account or by mail when your pregnancy-related disability claim ends.

If you are covered by a voluntary plan, contact your employer for information about your coverage and instructions on how to apply for benefits.

If your claim is denied, you have the right to:

- Know the reason for denial.
- Appeal decisions about your eligibility for benefits. Visit **Appeals (edd.ca.gov/Disability/Appeals.htm)** for information.

All claim information is confidential except for purposes allowed by law.

YOUR RIGHTS AND OBLIGATIONS AS A PREGNANT EMPLOYEE

DFEH

YOUR EMPLOYER HAS AN OBLIGATION TO:

- Reasonably accommodate your medical needs related to pregnancy, childbirth or related conditions (such as temporarily modifying your work duties, providing you with a stool or chair, or allowing more frequent breaks);
- Transfer you to a less strenuous or hazardous position (where one is available) or duties if medically needed because of your pregnancy; and
- Provide you with pregnancy disability leave (PDL) of up to four months (the working days you normally would work in one-third of a year or 17 1/3 weeks) and return you to your same job when you are no longer disabled by your pregnancy or, in certain instances, to a comparable job. Taking PDL, however, does not protect you from non-leave related employment actions, such as a layoff.
- Provide a reasonable amount of break time and use of a room or other location in close proximity to the employee's work area to express breast milk in private as set forth in the Labor Code.

FOR PREGNANCY DISABILITY LEAVE:

- PDL is not for an automatic period of time, but for the period of time that you are disabled by pregnancy. Your health care provider determines how much time you will need.
- Once your employer has been informed that you need to take PDL, your employer must guarantee in writing that you can return to work in your same position if you request a written guarantee. Your employer may require you to submit written medical certification from your health care provider substantiating the need for your leave.
- PDL may include, but is not limited to, additional or more frequent breaks, time for prenatal or postnatal medical appointments, doctor-ordered bed rest, severe morning sickness, gestational diabetes, pregnancy-induced hypertension, preeclampsia, recovery from childbirth or loss or end of pregnancy, and/or post-partum depression.
- PDL does not need to be taken all at once but can be taken on an as-needed basis as required by your health care provider, including intermittent leave or a reduced work schedule, all of which counts against your four month entitlement to leave.
- Your leave will be paid or unpaid depending on your employer's policy for other medical leaves. You may also be eligible for state disability insurance or Paid Family Leave (PFL), administered by the California Employment Development Department.
- At your discretion, you can use any vacation or other paid time off during your PDL.
- Your employer may require or you may choose to use any available sick leave during your PDL.
- Your employer is required to continue your group health coverage during your PDL at the same level and under the same conditions that coverage would have been provided if you had continued in employment continuously for the duration of your leave.
- Taking PDL may impact certain of your benefits and your seniority date; please contact your employer for details.
- If possible, you must provide at least 30 days' advance notice for foreseeable events (such as the expected birth of a child or a planned medical treatment for yourself). For events that are unforeseeable, we need you to notify your employer, at least verbally, as soon as you learn of the need for the leave. Failure to comply with these notice rules is grounds for, and may result in, deferral of the requested leave until you comply with this notice policy.

NOTICE OBLIGATIONS AS AN EMPLOYEE:

- Give your employer reasonable notice. To receive reasonable accommodation, obtain a transfer, or take PDL, you must give your employer sufficient notice for your employer to make appropriate plans. Sufficient notice means 30 days advance notice if the need for the reasonable accommodation, transfer, or PDL is foreseeable, otherwise as soon as practicable if the need is an emergency or unforeseeable.
- Provide a Written Medical Certification from Your Health Care Provider. Except in a medical emergency where there is no time to obtain it, your employer may require you to supply a written medical certification from your health care provider of the medical need for your reasonable accommodation, transfer or PDL. If the need is an emergency or unforeseeable, you must provide this certification within the time frame your employer requests, unless it is not practicable for you to do so under the circumstances despite your diligent, good faith efforts. Your employer must provide at least 15 calendar days for you to submit the certification. See your employer for a copy of a medical certification form to give to your health care provider to complete.
- Please note that if you fail to give your employer reasonable advance notice or, if your employer requires it, written medical certification of your medical need, your employer may be justified in delaying your reasonable accommodation, transfer, or PDL.

ADDITIONAL RIGHTS UNDER CALIFORNIA FAMILY RIGHTS ACT (CFRA) LEAVE AND NEW PARENT LEAVE ACT (NPLA):

Under the California Family Rights Act of 1993 (CFRA), if you have more than 12 months of service with us and have worked at least 1,250 hours in the 12-month period before the date you want to begin your leave, and if we employ 50 or more employees at your worksite or within 75 miles of your worksite, you may have a right to a family care or medical leave (CFRA leave). This leave may be up to 12 workweeks in a 12-month period for the birth, adoption, or foster care placement of your child or for your own serious health condition or that of your child, parent or spouse. If we employ less than 50 employees at your worksite or within 75 miles of your worksite, but at least 20 employees at your worksite or within 75 miles of your worksite, you may have a right to a family care leave for the birth, adoption, or foster care placement of your child under the New Parent Leave Act (NPLA). Similar to CFRA leave, the NPLA leave may be up to 12 workweeks in a 12-month period. While the law provides only unpaid leave, employees may choose or employers may require use of accrued paid leave while taking CFRA leave under certain circumstances and employees may choose to use accrued paid leave while taking NPLA leave.*

*CFRA and NPLA applies to all employees of the state of California and any other political or civil subdivision of the state and cities, regardless of the number of employees.

This notice is a summary of your rights and obligations under the Fair Employment and Housing Act (FEHA). For more information about your rights and obligations as a pregnant employee, contact your employer, visit the Department of Fair Employment and Housing's website at www.dfeh.ca.gov, or contact DFEH at (800) 884-1684 (voice or via relay operator 711), TTY (800) 700-2320, or contact.center@dfeh.ca.gov. The text of the FEHA and the regulations interpreting it are available on the Department of Fair Employment and Housing's website at www.dfeh.ca.gov.

CONTACT US

Toll Free: (800) 884-1684
TTY: (800) 700-2320
contact.center@dfeh.ca.gov
www.dfeh.ca.gov

DFEH-E09P-ENG / December 2019

TIME OF HIRE PAMPHLET

This pamphlet, or a similar one that has been approved by the Administrative Director, must 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. The content of this pamphlet applies to all industrial injuries that occur on or after January 1, 2013.

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 using vibrating tools, 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.

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, and costs and expenses set by state law.

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 and occupational therapy and chiropractic care.

- **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.

- **Permanent disability benefits**: Payments if you don't recover completely. You will be paid every two weeks if you are eligible. There are minimum and maximum weekly payment rates established by state law. The amount of payment is based on:

    - Your doctor's medical reports
    - Your age
    - Your occupation

- **Supplemental job displacement benefits**: This is a voucher for up to $6,000 that you can use for retraining or skill enhancement at an approved school, books, tools, licenses or certification fees, or other resources to help you find a new job. You are eligible for this voucher if:

    - You have a permanent disability.
    - Your employer does not offer regular, modified, or alternative work, within 60 days after the claims administrator receives a doctor's report saying you have made a maximum medical recovery.

- **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.

OTHER BENEFITS

You may file a claim with the Employment Development Department (EDD) to get state disability benefits when workers' compensation benefits are delayed, denied, or have ended. There are time restrictions so for more information contact the local office of EDD or go to their web site www.edd.ca.gov.

If your injury results in a permanent disability (PD) and the state determines that your PD benefit is disproportionately low compared to your earning loss, you may qualify for additional money from the Department of Industrial Relation's special earnings loss supplement program also known as the return to work program. If you have questions or think you qualify, contact the Information & Assistance Unit by going to www.dwc.ca.gov and looking under "Workers'

Compensation programs and units" for the "Information & Assistance Unit" link or visit the DIR web site at www.dir.ca.gov.

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.

If you cannot report to the employer or don't hear from the claims administrator after you have reported your injury, contact the claims administrator yourself.

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

State National under master Policy of Frontline HRO

Address: 1775 Parker Rd. Building C. Suite 210 Conyers, GA 30094

Phone: 888-623-4035 / risk@frontlinehro.com.

You may be able to find the name of your employer's workers' compensation insurer at www.caworkcompcoverage.com. If no coverage exists or coverage has expired, contact the Division of Labor Standards Enforcement at www.dir.ca.gov/DLSE as all employees must be covered by law.

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.

MORE ABOUT MEDICAL CARE

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. 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.

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 you have health care coverage for non-work injuries and illnesses. 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.

With some exceptions, state law does not allow a chiropractor to continue as your treating physician after 24 visits. Once you have received 24 chiropractic visits, if you still require medical treatment, you will have to select a new physician who is not a chiropractor. The term "chiropractic visit" means any chiropractic office visit, regardless of whether the services performed involve chiropractic manipulation or are limited to evaluation and management.

Exceptions to the prohibition on a chiropractor continuing as your treating physician after 24 visits include postsurgical physical medicine visits prescribed by the surgeon, or physician designated by the surgeon, under the postsurgical component of the Division of Workers' Compensation's Medical Treatment Utilization Schedule, or if your employer has authorized additional visits in writing.

WHAT IF THERE IS A PROBLEM?

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 and under "Workers' Compensation programs and units", click on "Information & Assistance Unit." At this site you will find fact sheets, guides and information to help you.

The nearest I&A Unit is located at:

Address: _____

Phone number: _____.

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 website 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.

Revised 6/17/14 and effective for dates of injuries on or after 1/1/13

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).

§ 9783.1. DWC Form 9783.1 Notice of Personal Chiropractor or Personal Acupuncturist.

NOTICE OF PERSONAL CHIROPRACTOR OR PERSONAL ACUPUNCTURIST

If your employer or your employer's insurer does not have a Medical Provider Network, you may be able to change your treating physician to your personal chiropractor or acupuncturist following a work-related injury or illness. In order to be eligible to make this change, you must give your employer the name and business address of a personal chiropractor or acupuncturist in writing prior to the injury or illness. Your claims administrator generally has the right to select your treating physician within the first 30 days after your employer knows of your injury or illness. After your claims administrator has initiated your treatment with another doctor during this period, you may then, upon request, have your treatment transferred to your personal chiropractor or acupuncturist.

NOTE: If your date of injury is January 1, 2004 or later, a chiropractor cannot be your treating physician after you have received 24 chiropractic visits unless your employer has authorized additional visits in writing. The term "chiropractic visit" means any chiropractic office visit, regardless of whether the services performed involve chiropractic manipulation or are limited to evaluation and management. Once you have received 24 chiropractic visits, if you still require medical treatment, you will have to select a new physician who is not a chiropractor. This prohibition shall not apply to visits for postsurgical physical medicine visits prescribed by the surgeon, or physician designated by the surgeon, under the postsurgical component of the Division of Workers' Compensation's Medical Treatment Utilization Schedule.

You may use this form to notify your employer of your personal chiropractor or acupuncturist.

Your Chiropractor or Acupuncturist's Information:

_____

(name of chiropractor or acupuncturist)

_____

(street address, city, state, zip code)

_____

(telephone number)

Employee Name **(please print**):

_____

Employee's Address:

_____

Employee's Signature _____ Date: _____

July 2014

FAMILY CARE & MEDICAL LEAVE & PREGNANCY DISABILITY LEAVE

DFEH

THE DEPARTMENT OF FAIR EMPLOYMENT AND HOUSING

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 AND HUMAN TRAFFICKING.

Under the California Family Rights Act of 1993 you may have a right to a family care or medical leave for the birth, adoption, or foster care placement of your child or for your own serious health condition or that of your child, parent or spouse. California law also prohibits employers from denying or interfering with requests for Pregnancy Disability Leave.

Under the California Family Rights Act of 1993 (CFRA), if you have more than 12 months of service with us and have worked at least 1,250 hours in the 12-month period before the date you want to begin your leave, and if we employ 50 or more employees at your worksite or within 75 miles of your worksite, you may have a right to a family care or medical leave (CFRA leave). This leave may be up to 12 workweeks in a 12-month period for the birth, adoption, or foster care placement of your child or for your own serious health condition or that of your child, parent or spouse. If we employ less than 50 employees at your worksite or within 75 miles of your worksite, but at least 20 employees at your worksite or within 75 miles of your worksite, you may have a right to a family care leave for the birth, adoption, or foster care placement of your child under the New Parent Leave Act (NPLA). Similar to CFRA leave, the NPLA leave may be up to 12 workweeks in a 12-month period. While the law provides only unpaid leave, employees may choose or employers may require use of accrued paid leave while taking CFRA leave under certain circumstances and employees may choose to use accrued paid leave while taking NPLA leave.

Even if you are not eligible for CFRA or NPLA leave, if you are disabled by pregnancy, childbirth or a related medical condition, you are entitled to take a pregnancy disability leave of up to four months, depending on your period(s) of actual disability. If you are CFRA or NPLA-eligible, you have certain rights to take BOTH a pregnancy disability leave and a CFRA or NPLA leave for reason of the birth of your child. Both leaves contain a guarantee of reinstatement-for pregnancy disability it is to the same position and for CFRA or NPLA it is to the same or a comparable position-at the end of the leave, subject to any defense allowed under the law.

If possible, you must provide at least 30 days' advance notice for foreseeable events (such as the expected birth of a child or a planned medical treatment for yourself or of a family member). For events that are unforeseeable, we need you to notify us, at least verbally, as soon as you learn of the need for the leave. Failure to comply with these notice rules is grounds for, and may result in, deferral of the requested leave until you comply with this notice policy.

We may require certification from your health care provider before allowing you a leave for pregnancy disability or for your own serious health condition. We also may require certification from the health care provider of your child, parent or spouse, who has a serious health condition, before allowing you a leave to take care of that family member. When medically necessary, leave may be taken on an intermittent or reduced work schedule.

If you are taking a leave for the birth, adoption, or foster care placement of a child, the basic minimum duration of the leave is two weeks, and you must conclude the leave within one year of the birth or placement for adoption or foster care.

Taking a family care or pregnancy disability leave may impact certain of your benefits and your seniority date. If you want more information regarding your eligibility for a leave and/or the impact of the leave on your seniority and benefits, please contact DFEH.

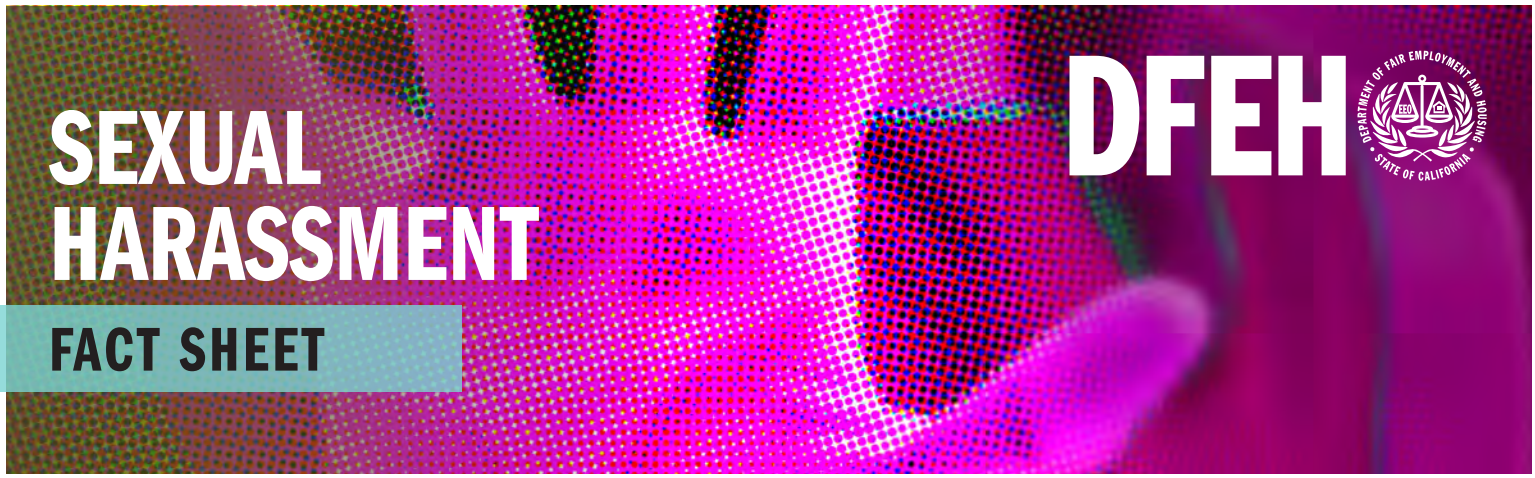
To schedule an appointment, contact the Communication Center below.

If you have a disability that requires a reasonable accommodation, the DFEH can assist you by scribing your intake by phone or, for individuals who are Deaf or Hard of Hearing or have speech disabilities, through the California Relay Service (711), or you can contact us below.

CONTACT US

Toll Free: (800) 884-1684
TTY: (800) 700-2320
contact.center@dfeh.ca.gov
www.dfeh.ca.gov

DFEH-100-21ENG / December 2019



SEXUAL HARASSMENT

FACT SHEET

DFEH

Sexual harassment is a form of discrimination based on sex/gender (including pregnancy, childbirth, or related medical conditions), gender identity, gender expression, or sexual orientation. Individuals of any gender can be the target of sexual harassment. Unlawful sexual harassment does not have to be motivated by sexual desire. Sexual harassment may involve harassment of a person of the same gender as the harasser, regardless of either person's sexual orientation or gender identity.

THERE ARE TWO TYPES OF SEXUAL HARASSMENT

1. "Quid pro quo" (Latin for "this for that") sexual harassment is when someone conditions a job, promotion, or other work benefit on your submission to sexual advances or other conduct based on sex.

2. "Hostile work environment" sexual harassment occurs when unwelcome comments or conduct based on sex unreasonably interferes with your work performance or creates an intimidating, hostile, or offensive work environment. You may experience sexual harassment even if the offensive conduct was not aimed directly at you.

The harassment must be severe or pervasive to be unlawful. A single act of harassment may be sufficiently severe to be unlawful.

SEXUAL HARASSMENT INCLUDES MANY FORMS OF OFFENSIVE BEHAVIORS

BEHAVIORS THAT MAY BE SEXUAL HARASSMENT:

1. Unwanted sexual advances
2. Offering employment benefits in exchange for sexual favors
3. Leering; gestures; or displaying sexually suggestive objects, pictures, cartoons, or posters
4. Derogatory comments, epithets, slurs, or jokes
5. Graphic comments, sexually degrading words, or suggestive or obscene messages or invitations
6. Physical touching or assault, as well as impeding or blocking movements

Actual or threatened retaliation for rejecting advances or complaining about harassment is also unlawful.

Employees or job applicants who believe that they have been sexually harassed or retaliated against may file a complaint of discrimination with DFEH within three years of the last act of harassment or retaliation.

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 to address the causes of the discrimination and on behalf of the complaining party. DFEH may seek court orders changing the employer's policies and practices, punitive damages, and attorney's fees and costs if it prevails in litigation. 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.

EMPLOYER RESPONSIBILITY & LIABILITY

All employers, regardless of the number of employees, are covered by the harassment provisions of California law. Employers are liable for harassment by their supervisors or agents. All harassers, including both supervisory and non-supervisory personnel, may be held personally liable for harassment or for aiding and abetting harassment. The law requires employers to take reasonable steps to prevent harassment. If an employer fails to take such steps, that employer can be held liable for the harassment. In addition, an employer may be liable for the harassment by a non-employee (for example, a client or customer) of an employee, applicant, or person providing services for the employer. An employer will only be liable for this form of harassment if it knew or should have known of the harassment, and failed to take immediate and appropriate corrective action.

Employers have an affirmative duty to take reasonable steps to prevent and promptly correct discriminatory and harassing conduct, and to create a workplace free of harassment.

A program to eliminate sexual harassment from the workplace is not only required by law, but it is the most practical way for an employer to avoid or limit liability if harassment occurs.

SEXUAL HARASSMENT

FACT SHEET

DFEH

CIVIL REMEDIES

- **Damages for emotional distress from each employer or person in violation of the law**
- **Hiring or reinstatement**
- **Back pay or promotion**
- **Changes in the policies or practices of the employer**

ALL EMPLOYERS MUST TAKE THE FOLLOWING ACTIONS TO PREVENT HARASSMENT AND CORRECT IT WHEN IT OCCURS:

1. Distribute copies of this brochure or an alternative writing that complies with Government Code 12950. This pamphlet may be duplicated in any quantity.

2. Post a copy of the Department's employment poster entitled "California Law Prohibits Workplace Discrimination and Harassment."

3. Develop a harassment, discrimination, and retaliation prevention policy in accordance with 2 CCR 11023. The policy must:

- Be in writing.
- List all protected groups under the FEHA.
- Indicate that the law prohibits coworkers and third parties, as well as supervisors and managers with whom the employee comes into contact, from engaging in prohibited harassment.
- Create a complaint process that ensures confidentiality to the extent possible; a timely response; an impartial and timely investigation by qualified personnel; documentation and tracking for reason able progress; appropriate options for remedial actions and resolutions; and timely closures.
- Provide a complaint mechanism that does not require an employee to complain directly to their immediate supervisor. That complaint mechanism must include, but is not limited to including: provisions for direct communication, either orally or in writing, with a designated company representative; and/or a complaint hotline; and/or access to an ombudsperson; and/or identification of DFEH and the United States Equal Employment Opportunity Commission as additional avenues for employees to lodge complaints.
- Instruct supervisors to report any complaints of misconduct to a designated company representative, such as a human resources manager, so that the company can try to resolve the claim internally. Employers with 50 or more employees are required to include this as a topic in mandated sexual harassment prevention training (see 2 CCR 11024).
- Indicate that when the employer receives allegations of misconduct, it will conduct a fair, timely, and thorough investigation that provides all parties appropriate due process and reaches reasonable conclusions based on the evidence collected.
- Make clear that employees shall not be retaliated against as a result of making a complaint or participating in an investigation.

4. Distribute its harassment, discrimination, and retaliation prevention policy by doing one or more of the following:

- Printing the policy and providing a copy to employees with an acknowledgement form for employees to sign and return.
- Sending the policy via email with an acknowledgment return form.
- Posting the current version of the policy on a company intranet with a tracking system to ensure all employees have read and acknowledged receipt of the policy.
- Discussing policies upon hire and/or during a new hire orientation session.
- Using any other method that ensures employees received and understand the policy.

5. If the employer's workforce at any facility or establishment contains ten percent or more of persons who speak a language other than English as their spoken language, that employer shall translate the harassment, discrimination, and retaliation policy into every language spoken by at least ten percent of the workforce.

6. In addition, employers who do business in California and employ 5 or more part-time or full-time employees must provide at least one hour of training regarding the prevention of sexual harassment, including harassment based on gender identity, gender expression, and sexual orientation, to each non-supervisory employee; and two hours of such training to each supervisory employee. Training must be provided within six months of assumption of employment. Employees must be trained during calendar year 2019, and, after January 1, 2020, training must be provided again every two years. Please see Gov. Code 12950.1 and 2 CCR 11024 for further information.

TO FILE A COMPLAINT

Department of Fair Employment and Housing
dfeh.ca.gov
Toll Free: 800.884.1684
TTY: 800.700.2320

DFEH-185-ENG / April 2020

EMPLOYERS MUST PROVIDE THIS INFORMATION TO NEW WORKERS WHEN HIRED AND TO OTHER WORKERS WHO ASK FOR IT

RIGHTS OF VICTIMS OF DOMESTIC VIOLENCE, SEXUAL ASSAULT AND STALKING

Your Right to Take Time Off:

- You have the right to take time off from work to get help to protect you and your children's health, safety or welfare. You can take time off to get a restraining order or other court order.
- If your company has 25 or more workers, you can take time off from work to get medical attention or services from a domestic violence shelter, program or rape crisis center, psychological counseling, or receive safety planning related to domestic violence, sexual assault, or stalking.
- You may use available vacation, personal leave, accrued paid sick leave or compensatory time off for your leave unless you are covered by a union agreement that says something different. Even if you don't have paid leave, you still have the right to time off.
- In general, you don't have to give your employer proof to use leave for these reasons.
- If you can, you should tell your employer before you take time off. Even if you cannot tell your employer before, your employer cannot discipline you if you give proof explaining the reason for your absence within a reasonable time. Proof can be a police report, court order or doctor's or counselor's note or similar document.

Your Right to Reasonable Accommodation:

- You have the right to ask your employer for help or changes in your workplace to make sure you are safe at work. Your employer must work with you to see what changes can be made. Changes in the workplace may include putting in locks, changing your shift or phone number, transferring or reassigning you, or help with keeping a record of what happened to you. Your employer can ask you for a signed statement certifying that your request is for a proper purpose, and may also request proof showing your need for an accommodation. Your employer cannot tell your coworkers or anyone else about your request.

Your Right to Be Free from Retaliation and Discrimination:

Your employer cannot treat you differently or fire you because:

- You are a victim of domestic violence, sexual assault, or stalking.
- You asked for leave time to get help.
- You asked your employer for help or changes in the workplace to make sure you are safe at work.

You can file a complaint with the Labor Commissioner's Office against your employer if he/she retaliates or discriminates against you.

For more information, contact the California Labor Commissioner's Office. We can help you by phone at 213-897-6595, or you can find a local office on our website: www.dir.ca.gov/dlse/DistrictOffices.htm. If you do not speak English, we will provide an interpreter in your language at no cost to you. This Notice explains rights contained in California Labor Code sections 230 and 230.1. Employers may use this Notice or one substantially similar in content and clarity.