**FEDERAL WORK STUDY**  
**STUDENT EMPLOYMENT AUTHORIZATION**

Form to be Completed by the Hiring Department (Supervisor) for Federal Work Study. All appropriate fields must be complete or form will not be accepted.

### ACTION REQUESTED:

- [ ] New Hire  
  Start Date: ___________________________  
  End Date: ___________________________

- [ ] Rehired to same or new Department  
  Start Date: ___________________________  
  End Date: ___________________________

- [ ] Step Increase*  
  Start Date: ___________________________  
  A justification for any step increase or pay level change must be attached.

- [ ] Pay Level Change*  
  Start Date: ___________________________  
  ___________________________

- [ ] Funding Source Change  
  Start Date: ___________________________  
  ___________________________

- [ ] Termination  
  Term Date: ___________________________  
  Last Day Worked: ____________________

### PLEASE PRINT:

**STUDENT'S NAME:** ___________________________ FIRST  
_________________________ MIDDLE  
_________________________ LAST

**STUDENT ID:** ___________________________

Please circle:  
Level I ($10.00/hr.)  
Level II ($10.50/hr.)  
Level III ($11.00/hr.)  
Level IV ($11.50/hr.)

**DEPARTMENT NAME:** ___________________________  
**DEPT. ID:** ___________________________

**SUPERVISOR'S NAME (Please Print):** ___________________________

**SUPERVISOR'S SIGNATURE:** ___________________________  
**DATE:** ___________________________

**DEPARTMENT HEAD'S SIGNATURE:** ___________________________  
**DATE:** ___________________________

---

**NOTE:** This form will be returned to the Department/Supervisor once the HR Department Representative has signed confirming that the student has completed employment documents. At that point, the student may begin work.

1. Federal law requires that all employees complete their Employment Eligibility Verification form (I-9) Employees must also provide acceptable individual identification. A list of acceptable documents for the I-9 is available on the reverse side of the form.

2. International students must present an original visa, passport, and work authorization.

3. Permanent resident aliens must present a Permanent Resident Card.

4. Cal Maritime is required to verify each employee's Social Security Number before employment begins. Employees must bring their Social Security card or proof of application for a Social Security number to the Human Resources Office in order to complete hiring documents.

Financial Aid Representative Confirmation: ___________________________ Date: ___________________________

HR Representative Confirmation: ___________________________ Date: ___________________________

Copies to Department and Student Employee

Rev. 9/15
**Emergency Contact Information**

*CAL MARITIME*

<table>
<thead>
<tr>
<th><strong>Emergency Contact Information:</strong> (Person(s) to contact in an emergency.)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Name:</strong></td>
</tr>
<tr>
<td><strong>Address:</strong></td>
</tr>
<tr>
<td><strong>City:</strong></td>
</tr>
<tr>
<td><strong>Home Phone:</strong></td>
</tr>
</tbody>
</table>
**CSU STUDENT PAYROLL**

**ACTION REQUEST**

THIS IS CARBONLESS PAPER. PRINT CLEARLY. USE BALLPOINT PEN.

See Instructions on reverse of this form before completing.

<table>
<thead>
<tr>
<th>TYPE OF TRANSACTION</th>
<th>OFFICE USE ONLY</th>
</tr>
</thead>
<tbody>
<tr>
<td>A06 NEW EMPLOYEE INFORMATION</td>
<td>A01 AGENCY</td>
</tr>
<tr>
<td>C03 WITHHOLDING ALLOWANCE CHANGE</td>
<td>A02 UNIT</td>
</tr>
<tr>
<td>E04 ADDRESS CHANGE (C, D, E)</td>
<td>A03 CLASS</td>
</tr>
<tr>
<td>E05 NAME CHANGE (C, D, E)</td>
<td>A04 SERIAL</td>
</tr>
<tr>
<td>E07 BIRTHDATE CHANGE (C, G, I)</td>
<td></td>
</tr>
<tr>
<td>105 SSA NUMBER CHANGE (C, G)</td>
<td></td>
</tr>
<tr>
<td>445 ETHNIC CORRECTION (G, I)</td>
<td></td>
</tr>
<tr>
<td>CAMPUS USE ONLY</td>
<td></td>
</tr>
<tr>
<td>DESIGNEE CHANGE (C, G, I)</td>
<td></td>
</tr>
</tbody>
</table>

**WITHHOLDING ALLOWANCE CERTIFICATE** **IMPORTANT**

Before completing Section H you must read IRS Form W-4 or W-4A and state tax Form DE-4.

<table>
<thead>
<tr>
<th><strong>I. FEDERAL AND STATE ALLOWANCES</strong></th>
<th>00 SOCIAL SECURITY NUMBER</th>
</tr>
</thead>
<tbody>
<tr>
<td>01 If no tax should be withheld, complete Part III or IV only.</td>
<td>02 EMPLOYEE LAST NAME</td>
</tr>
<tr>
<td>MARITAL STATUS (Check One)</td>
<td>03 FIRST NAME AND MIDDLE INITIAL</td>
</tr>
<tr>
<td>FOR TAX PURPOSES ONLY</td>
<td></td>
</tr>
<tr>
<td>SINGLE</td>
<td>TOTAL ALLOWANCES</td>
</tr>
<tr>
<td>MARRIED</td>
<td>02 NONRESIDENT ALIEN</td>
</tr>
<tr>
<td>NONRESIDENT ALIEN</td>
<td>05 TOTAL ALLOWANCES</td>
</tr>
</tbody>
</table>

**NOTE:** Employers may notify IRS if more than 10 allowances are claimed.

<table>
<thead>
<tr>
<th><strong>II. SPECIAL TREATMENT OF STATE ALLOWANCES</strong></th>
<th>03 HEAD OF FAMILY ALLOWANCES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complete boxes 03 thru 05 if you wish your California state withholding to be different than what you claim for federal withholding.</td>
<td>04 ADDITIONAL ALLOWANCES</td>
</tr>
<tr>
<td>FOR TAX PURPOSES ONLY</td>
<td>05 ADDITIONAL ALLOWANCES</td>
</tr>
<tr>
<td>SINGLE</td>
<td>03 HEAD OF FAMILY</td>
</tr>
<tr>
<td>MARRIED</td>
<td>04 ADDITIONAL ALLOWANCES</td>
</tr>
<tr>
<td>NONRESIDENT ALIEN</td>
<td>05 ADDITIONAL ALLOWANCES</td>
</tr>
</tbody>
</table>

**NOTE:** Employers may be required to notify EDD if more than 10 allowances are claimed.

<table>
<thead>
<tr>
<th><strong>III. EXEMPTION FROM WITHHOLDING</strong></th>
<th>06 HEAD OF SCHOOL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complete box 06 if you are eligible to claim exemption from withholding. No Federal or State income tax will be withheld from your wages. DO NOT COMPLETE PARTS I or II. (See General Information - fourth page.)</td>
<td>07 NONRESIDENT ALIEN</td>
</tr>
<tr>
<td>I claim exemption from withholding because of no tax liability: Last year 06 I did not owe any income tax and had a right to a full refund of ALL income tax withheld, and this year 07 I do not expect to owe any income tax and expect to have a right to a full refund of ALL income tax withheld.</td>
<td>08 NONEXEMPT</td>
</tr>
<tr>
<td>If you are not having income tax withheld this year but expect to have a tax liability next year, you must file a withholding allowance claim by December 1st of this year. This exemption will automatically expire on February 15th of next year unless you file a new certification by January 31st of next year.</td>
<td>09 EMPLOYER</td>
</tr>
<tr>
<td>Investors are required to notify IRS if you earn more than $200 per week.</td>
<td>10 10</td>
</tr>
</tbody>
</table>

**IV. NONTAXABLE WAGES-Complete box 07 If wages you will receive are not subject to income tax withholding. (See General Information-fourth page.)**

| 07 I claim that the wages I will be receiving from the State are either 1) MINISTER OF A CHURCH, 2) NONRESIDENT ALIEN wages, or 3) Deceased Employee Wages. Indicate reason: |

**EMPLOYEE CERTIFICATION**

I certify the above Information is true and that I have read IRS Form W-4 or W-4A and state Form DE-4. Under the penalties of perjury, I certify that the number of withholding exemptions and allowances claimed does not exceed the number to which I am entitled. If claiming exemption from withholding, I certify I have not incurred tax liability for last year and I anticipate I will incur no liability this year. I authorize my employer to withhold any overcollection of my current year income tax and pay the overcollection to the controller. If completing Section K, I hereby revoke any previous designation. If completing Section L, I hereby subscribe to the oath of allegiance or declaration of permission to work.

<table>
<thead>
<tr>
<th>SIGNATURE</th>
<th>DATE</th>
</tr>
</thead>
</table>

**CSU REPRESENTATIVE SIGNATURE**

I authorize the State Controller to take the action indicated herein and do certify that the action is appropriate. I have reviewed the completion of this document and where appropriate, witnessed the subscription to the oath of allegiance or declaration of permission to work.

<table>
<thead>
<tr>
<th>SIGNATURE</th>
<th>DATE</th>
</tr>
</thead>
</table>

**DESIGNEE FOR STATE WARRANT(S)**

<table>
<thead>
<tr>
<th>01 DESIGNEE FIRST NAME AND INITIAL</th>
<th>02 LAST NAME</th>
</tr>
</thead>
<tbody>
<tr>
<td>03 RELATIONSHIP</td>
<td>04 RELATIONSHIP</td>
</tr>
<tr>
<td>05 DESIGNEE ADDRESS (Street, P.O. Box, or Rural Route)</td>
<td>06 CITY AND STATE</td>
</tr>
<tr>
<td>07 ZIP CODE</td>
<td>08 ZIP CODE</td>
</tr>
</tbody>
</table>

**OATH OF ALLEGIANCE/DECLARATION OF PERMISSION TO WORK** Complete Part I or Part II

<table>
<thead>
<tr>
<th><strong>PART I - OATH OF ALLEGIANCE</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>I,</td>
</tr>
<tr>
<td>do solemnly swear (or affirm) that I will support and defend the Constitution of the United States and the Constitution of the State of California against all enemies, foreign and domestic; that I will bear true faith and allegiance to the Constitution of the United States and the Constitution of the State of California; that I take this obligation freely without any mental reservation or purpose of evasion; and that I will well and faithfully discharge the duties upon which I am about to enter. I hereby subscribe to this oath by signing in Section I above.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PART II - DECLARATION OF PERMISSION TO WORK</th>
<th>YES:</th>
</tr>
</thead>
<tbody>
<tr>
<td>I am a lawful permanent resident noncitizen of the United States.</td>
<td>IF &quot;NO&quot;, I hereby certify that I have permission to work in this country and have declared any restrictions placed upon me in this regard by the United States government to the appointing power.</td>
</tr>
<tr>
<td>NO</td>
<td></td>
</tr>
</tbody>
</table>

**DISTRIBUTION:**

BLUE - Personnel/Payroll Division; PINK/YELLOW - Campus Copies; GREEN - Employee
PRIVATE INFORMATION

The Information Practices Act of 1977 (California Civil Code § 1798.17) and the Federal Privacy Act (5 USC 552a, subd. (q)(3)) require this notice be provided when collecting personal information from individuals.

The Information you are asked to provide on this form is requested by the Office of the State Controller, Personnel/Payroll Services Division. Furnishing the information requested on this form is mandatory. Noncompliance in providing your Social Security Number and name will result in refusal of employment.

Information requested on this form is used for personnel, payroll and related processing. Legal references authorizing the maintenance of this Information by the State Controller's Office includes: Federal Internal Revenue Code (26 USC §§ 402(a), 6011, 6051, 6109) and the regulations thereto; federal Public Health and Welfare Code (42 USC § 405); California Government Code (§§ 12470 through 12479 and 16391 through 16395); California Unemployment Insurance Code § 13020; delegated authority from the Trustees of the California State University.

Certain items of Information furnished on this form may be transferred to the following governmental or private agencies where authorized by law: Trustees, The California State University, Employment Development Department, Department of Social Services, employing State agencies and campuses, Social Security Administration, Federal Internal Revenue Service, California State Franchise Tax Board, other state income tax bureaus and other governmental agencies when required by state or federal law, and organizations for which deductions are authorized by law.

Employees have the right to review their own personal Information maintained by the State Controller's Office, unless access is exempted by law. Contact: Personnel/Payroll Services Division, State Controller's Office, Post Office Box 942850, Sacramento, California 94262-6576.

EMPLOYEES WITH TWO OR MORE CONCURRENT JOBS WITH THE STATE OF CALIFORNIA. The allowances you claim on this form will be used for tax withholding purposes for all wages paid under the Uniform State Payroll System. The Uniform State Payroll System includes all California State Agencies (except as noted below), and the California State Universities. It does not include the California Agricultural Associations, Legislative employees, or the Universities of California.

IF YOU DO NOT COMPLETE SECTION H. If you are new to State service and you fail to complete Section H, you will be treated for withholding tax purposes as a single person claiming no allowances (Section 3402(c) and Section 3402(1) of the Internal Revenue Code).

If you are returning to State service and you fail to complete Section H and you have received within the past year, earnings paid under the Uniform State Payroll System, taxes will be withheld from your wages based on the allowances you previously claimed.

IF YOU ARE EXEMPT FROM EITHER FEDERAL OR STATE WITHHOLDING but not exempt from both, contact your personnel/payroll office for special instructions for completing Section H.

IF YOU ARE A NONRESIDENT ALIEN PER INTERNAL REVENUE SERVICE (IRS) NOTICE 2005-76 check the Nonresident Alien box. If you have questions as to whether you should mark this box, you should contact your human resources officer.

IF YOU WILL RECEIVE NONTAXABLE WAGES, please indicate the reason on your withholding claim in the space provided. The reason must be one of the following:

a. "Minister of a Church*" employed by the State of California as a Minister of a Church
b. "Nonresident Alien per Tax Treaty*" (Indicate on claim: "Exempt per Article of treaty between the United States and (country)"

Tax Treaty must oblige exemption from both Federal and State personal income tax to qualify for this exemption.

c. "Deceased Employee Wages*"-campus administrative action.

If you have any questions regarding your eligibility under any of the above reasons, you should contact your local Internal Revenue Service Office or the Employment Tax District Office of the Employment Development Department.

STUDENT PAYROLL ACTION REQUEST INSTRUCTIONS

Read all instructions before completing this form. Use pen and print all entries. Sign your name in Section I. Retain the 4th (Green) copy for your records. If you have questions about any item on this form, consult your personnel/payroll office.

SECTION B
Type of Transaction - Check all appropriate boxes and complete listed sections.

SECTION C
Social Security Number - Enter your number as it appears on your social security card. If you do not have a social security card, you must apply for your card through the Social Security Administration using the application for a social security number, SS-5. In the box for social security number on STD. 457 you should write "SS-5 SSN". A copy of the SS-5 form should be attached to the STD. 457. When you receive your social security number, please notify your personnel/payroll office.

Name - Enter your name as it appears on your social security card. Enter last name first. This same name must be used on all future employment documents unless formally changed by you.

Name Change - Complete a new STD. 457 in your personnel/payroll office. You must also submit a name change form (SS-5) to the Social Security Administration. A copy of the name change form (SS-5) or the receipt issued by the Social Security Administration (SSA-5028-374) must be attached to the STD. 457.

SECTION D
Address - Enter your mailing address. This address will be used for W-2 statements and mailing of final warrants, if any. Notify your employer immediately if your address changes. Complete a new STD. 457 in your personnel/payroll office.

SECTION E
Birthdate - Enter numerically the month, day, and year of your birth. (March 20, 1949 enter 03/20/49)

SECTION F
Sex - Enter "M" for Male or "F" for Female.

SECTION G
Ethnic Code - Enter the code of the ethnic group with which you most closely identify yourself from the chart below. This request is consistent with U.S. Department of Labor Regulations mandated by Federal Executive Orders 11246 and 11375. This confidential information does not become part of an employee's personnel file. The employer is required to make a visual identification of those individuals who do not complete this item.

<table>
<thead>
<tr>
<th>RACE/ETHNICITY</th>
<th>ETHNIC CODE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mexican, Mexican-American, Chicano</td>
<td>A</td>
</tr>
<tr>
<td>Puerto Rican</td>
<td>B</td>
</tr>
<tr>
<td>Cuban</td>
<td>C</td>
</tr>
<tr>
<td>Other Spanish-Speaking</td>
<td>D</td>
</tr>
<tr>
<td>White</td>
<td>E</td>
</tr>
<tr>
<td>Black</td>
<td>F</td>
</tr>
<tr>
<td>Filipino</td>
<td>G</td>
</tr>
<tr>
<td>Hawaiian or Pacific Islander</td>
<td>H</td>
</tr>
<tr>
<td>Asian</td>
<td>I</td>
</tr>
<tr>
<td>Other Asian</td>
<td>J</td>
</tr>
<tr>
<td>Native American</td>
<td>K</td>
</tr>
<tr>
<td>Other Pacific Islander</td>
<td>L</td>
</tr>
<tr>
<td>Other RACE/ETHNICITY</td>
<td>M</td>
</tr>
</tbody>
</table>

SECTION H

Part I - Federal and State Allowances
Part II - Special Treatment of State Allowance
Part III - Exemption from Withholding
Part IV - Nontaxable Wages

Use worksheets on Internal Revenue Service Form W-4 or W-4A and California to complete your withholding allowances.

See General Information above.

SECTION I
Employee Certification - You must sign your name, certifying to the accuracy of information entered on the form.

SECTION K

Designee for State Payroll Warrants (G.C. 12470) - This item must be completed by all employees. Notwithstanding any other provision of law, the person you designate, if 18 years or older, shall be entitled upon your death to receive all State warrants due you, excluding retirement benefits. Your designee must file written request for such warrants with your personnel office within 60 days after the date of your death. NOTE: If you make an error in designee name, you must complete a new STD. 457.

Designee Name - Enter the full name (Mary Jane Smith not Mrs. Robert L. Smith) in K01 and K02. Specify the relationship of the person designated in K03 (e.g., wife, husband, domestic partner, daughter, son, mother, father, parent, friend). Enter address in K05 to K07. If you have no designee, enter "NONE" in K01.

Designee Address - Enter the permanent mailing address. File a new STD. 457 anytime your designee's address changes.

Designee Change - You may change or revoke your designee at any time by completing a new STD. 457.

SECTION L

Oath of Allegiance or Declaration of Permission to Work - Complete Part 1 or Part 2. Every State employee, except legally employed noncitizens, must sign the Oath (Part 1). The Declaration of Permission to Work (Part 2) is required of noncitizens. If you are a nonresident, noncitizen employee and become a naturalized citizen, an oath must be signed and filed.

The Oath/Declaration must be signed before entering into employment. Payment may not be made to any CSU employee unless the employee has taken and subscribed to the Oath/Declaration.

Penalties (G.C. 3108) - "Every person who, while taking and subscribing to the Oath or affirmation required by this chapter, states as true any material matter which he/she knows to be false, is guilty of perjury, and is punishable by imprisonment in the state prison not less than one nor more than 14 years."
INFORMATION ABOUT SOCIAL SECURITY FORM SSA-1945
STATEMENT CONCERNING YOUR EMPLOYMENT IN A JOB NOT COVERED BY SOCIAL SECURITY

LEGAL REQUIREMENT
The Social Security Protection Act of 2004 (SSPA), Public Law 108-203, requires State, including the California State University (CSU), and local government employers to provide a statement to employees hired January 1, 2005, or later, in a job not covered under Social Security. The statement explains how a pension from that job could affect future Social Security benefits to which they may become entitled.

CSU FORM SSA-1945, Statement Concerning Your Employment in a Job Not Covered by Social Security, is the document campuses should use to meet the requirements of the law. CSU FORM SSA-1945 explains the potential effects of two provisions in the Social Security law for workers who also receive a pension based on their work in a job not covered by Social Security. The Windfall Elimination Provision can affect the amount of a worker’s Social Security retirement or disability benefit. The Government Pension Offset Provision can affect a Social Security benefit received as a spouse or an ex-spouse.

In accordance with the Social Security Protection Act of 2004, employers must:
- Give the statement to the employee prior to the start of employment;
- Obtain the employee's signature on the form; and
- Submit a copy of the signed form to the pension-paying agency, if appropriate.

Social Security will not be setting any additional guidelines concerning the use of this form.

WHO MUST SIGN THE FORM
All new hires who fall into the following categories must complete the form:
- Public Safety employees who participate in the CalPERS public safety retirement plan and do not pay Social Security taxes;
- Student employees who are exempt from paying social security taxes, including those who do not contribute to a retirement system;
- Employees who are exempt from paying social security taxes due to non-resident alien tax status; or
- Part-time, seasonal and temporary employees who participate in a defined contribution plan in lieu of Social Security (DPA PST Retirement Plan and the UCDC plan) authorized by the Omnibus Budget and Reconciliation Act (OBRA).

FORM COMPLETION DEADLINE
Employees in above categories must receive, complete and sign the form prior to the start of employment. Please note: an employee must complete the form each time he or she is newly hired or rehired in a new appointment in one of the above categories.

COMPLETING THE FORM
The designated University representative responsible for disseminating the form must make sure that the form is filled out completely and includes a signature and date.

DISTRIBUTION OF SIGNED FORM:
For employees eligible for the UCDC plan, please mail form to:
UC HR/Benefits - Records Management
P.O. Box 24570
Oakland, CA 94623-1570

For employees eligible for CalPERS membership, please mail form to:
CalPERS – Form SSA-1945
P.O. Box 942715
Sacramento, CA 94229-2715

Note: Do not mail forms for the DPA PST Plan, as this plan does not meet the criteria of a pension-paying agency.

ADDITIONAL INSTRUCTIONS:
Provide a photocopy of the form to the employee.
CSU FORM SSA-1945
STATEMENT CONCERNING YOUR EMPLOYMENT IN A JOB NOT COVERED BY SOCIAL SECURITY

EMPLOYEE AND CAMPUS INFORMATION
EMPLOYEE NAME (Last, First, Middle Initial)  
EMPLOYEE ID #

CAMPUS  
DEPARTMENT

Please be advised that your earnings from this position are not covered under Social Security. When you retire, or if you become disabled, you may receive a pension based on earnings from this position. If you do, and you are also entitled to a benefit from Social Security based on either your own work or the work of your husband or wife, or former husband or wife, your pension benefit may affect the amount of the Social Security Benefit you receive. Your Medicare benefits, however, will not be affected.

Under the Social Security law, there are two (2) ways your Social Security benefit amount may be affected:

1. Windfall Elimination Provision
Under the Windfall Elimination Provision, your Social Security retirement or disability benefit is figured using a modified formula when you are also entitled to a pension from a job where you did not pay Social Security tax. As a result, you will receive a lower Social Security benefit than if you were not entitled to a pension from this job.

For example, if you are age 62 in 2005, the maximum monthly reduction in your Social Security benefit as a result of this provision is $313.50. This amount is updated annually. This provision reduces, but does not totally eliminate, your Social Security benefit.

2. Government Pension Offset Provision
Under the Government Pension Offset Provision, any Social Security spouse or widow(er) benefit to which you become entitled will be offset if you also receive a Federal, State, or local government pension based on work where you did not pay Social Security tax. The offset reduces the amount of your Social Security spouse or widow(er) benefit by two-thirds (2/3) of the amount of your pension.

For example, if you get a monthly pension of $600 based on earnings that are not covered under Social Security, two-thirds of that amount, $400, is used to offset your Social Security spouse or widow(er) benefit. If you are eligible for a $500 widow(er) benefit, you will receive $100 per month from Social Security ($500-$400 = $100). Even if your pension is high enough to totally offset your spouse or widow(er) Social Security benefit, you are still eligible for Medicare at age 65.

FOR ADDITIONAL INFORMATION
For more information, please refer to Social Security Publications “Windfall Elimination Provision,” and “Government Pension Offset Provision.” These publications, and additional pertinent information, including information about exceptions to each provision, are available at www.socialsecurity.gov. You may also call toll free at (800) 772-1213, or the TTY number at (800) 325-0778, or contact your local Social Security Office.

REQUIRED SIGNATURE
I certify that I have received CSU FORM SSA-1945 that contains information about the possible effects of the Windfall Elimination Provision and the Government Pension Offset Provision on my potential future Social Security benefits.

SIGNATURE OF EMPLOYEE  
DATE

CAMPUS NAME  
EMPLOYER ID #
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.)

<table>
<thead>
<tr>
<th>Last Name (Family Name)</th>
<th>First Name (Given Name)</th>
<th>Middle Initial</th>
<th>Other Names Used (if any)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Address (Street Number and Name)</th>
<th>Apt. Number</th>
<th>City or Town</th>
<th>State</th>
<th>Zip Code</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Date of Birth (mm/dd/yyyy)</th>
<th>U.S. Social Security Number</th>
<th>E-mail Address</th>
<th>Telephone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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):

- [ ] A citizen of the United States
- [ ] A noncitizen national of the United States (See instructions)
- [ ] A lawful permanent resident (Alien Registration Number/USCIS Number): __________________________

- [ ] An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy) __________________________. Some aliens may write "N/A" in this field. (See Instructions)
  For aliens authorized to work, provide your Alien Registration Number/USCIS Number OR Form I-94 Admission Number:
  1. Alien Registration Number/USCIS Number: __________________________
  2. Form I-94 Admission Number: __________________________

If you obtained your admission number from CBP in connection with your arrival in the United States, include the following:

Foreign Passport Number: __________________________
Country of Issuance: __________________________

Some aliens may write "N/A" on the Foreign Passport Number and Country of Issuance fields. (See Instructions)

Signature of Employee: __________________________
Date (mm/dd/yyyy): __________________________

Preparers and/or Translator Certification (To be completed and signed if Section 1 is prepared by a person other than the employee.)

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

Signature of Preparer or Translator: __________________________
Date (mm/dd/yyyy): __________________________

<table>
<thead>
<tr>
<th>Last Name (Family Name)</th>
<th>First Name (Given Name)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Address (Street Number and Name)</th>
<th>City or Town</th>
<th>State</th>
<th>Zip Code</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Employer Completes Next Page
**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 examine a combination of one document from List B and one document from List C as listed on the “Lists of Acceptable Documents” on the next page of this form. For each document you review, record the following information: document title, issuing authority, document number, and expiration date, if any.

Employee Last Name, First Name and Middle Initial from Section 1:

<table>
<thead>
<tr>
<th>List A</th>
<th>OR</th>
<th>List B</th>
<th>AND</th>
<th>List C</th>
</tr>
</thead>
<tbody>
<tr>
<td>Document Title:</td>
<td>Document Title:</td>
<td>Document Title:</td>
<td>Document Title:</td>
<td></td>
</tr>
<tr>
<td>Issuing Authority:</td>
<td>Issuing Authority:</td>
<td>Issuing Authority:</td>
<td>Issuing Authority:</td>
<td></td>
</tr>
<tr>
<td>Document Number:</td>
<td>Document Number:</td>
<td>Document Number:</td>
<td>Document Number:</td>
<td></td>
</tr>
<tr>
<td>Expiration Date (if any) (mm/dd/yyyy):</td>
<td>Expiration Date (if any) (mm/dd/yyyy):</td>
<td>Expiration Date (if any) (mm/dd/yyyy):</td>
<td>Expiration Date (if any) (mm/dd/yyyy):</td>
<td></td>
</tr>
</tbody>
</table>

**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.)

<table>
<thead>
<tr>
<th>Signature of Employer or Authorized Representative</th>
<th>Date (mm/dd/yyyy)</th>
<th>Title of Employer or Authorized Representative</th>
</tr>
</thead>
<tbody>
<tr>
<td>Last Name (Family Name)</td>
<td>First Name (Given Name)</td>
<td>Employer’s Business or Organization Name</td>
</tr>
<tr>
<td>200 Maritime Academy Drive</td>
<td>Vallecito</td>
<td>Cal Maritime</td>
</tr>
</tbody>
</table>

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

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

C. If employee’s previous grant of employment authorization has expired, provide the information for the document from List A or List C the employee presented that establishes current 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: | Date (mm/dd/yyyy): | Print 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.

<table>
<thead>
<tr>
<th>LIST A</th>
<th>OR</th>
<th>LIST B</th>
<th>AND</th>
<th>LIST C</th>
</tr>
</thead>
<tbody>
<tr>
<td>Documents that Establish Both Identity and Employment Authorization</td>
<td></td>
<td>Documents that Establish Identity</td>
<td></td>
<td>Documents that Establish Employment Authorization</td>
</tr>
<tr>
<td>1. U.S. Passport or U.S. Passport Card</td>
<td></td>
<td>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</td>
<td></td>
<td>1. A Social Security Account Number card, unless the card includes one of the following restrictions:</td>
</tr>
<tr>
<td>2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)</td>
<td></td>
<td>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</td>
<td></td>
<td>(1) NOT VALID FOR EMPLOYMENT</td>
</tr>
<tr>
<td>3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa</td>
<td></td>
<td>3. School ID card with a photograph</td>
<td></td>
<td>(2) VALID FOR WORK ONLY WITH INS AUTHORIZATION</td>
</tr>
<tr>
<td>4. Employment Authorization Document that contains a photograph (Form I-766)</td>
<td></td>
<td>4. Voter’s registration card</td>
<td></td>
<td>(3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION</td>
</tr>
<tr>
<td>5. For a nonimmigrant alien authorized to work for a specific employer because of his or her status:</td>
<td></td>
<td>5. U.S. Military card or draft record</td>
<td></td>
<td>2. Certification of Birth Abroad issued by the Department of State (Form FS-545)</td>
</tr>
<tr>
<td>a. Foreign passport; and</td>
<td></td>
<td>6. Military dependent’s ID card</td>
<td></td>
<td>3. Certification of Report of Birth issued by the Department of State (Form DS-1350)</td>
</tr>
<tr>
<td>b. Form I-94 or Form I-94A that has the following:</td>
<td></td>
<td>7. U.S. Coast Guard Merchant Mariner Card</td>
<td></td>
<td>4. Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal</td>
</tr>
<tr>
<td>(1) The same name as the passport and</td>
<td></td>
<td>8. Native American tribal document</td>
<td></td>
<td>5. Native American tribal document</td>
</tr>
<tr>
<td>(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.</td>
<td></td>
<td>9. Driver’s license issued by a Canadian government authority</td>
<td></td>
<td>6. U.S. Citizen ID Card (Form I-197)</td>
</tr>
<tr>
<td>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</td>
<td></td>
<td><strong>For persons under age 18 who are unable to present a document listed above:</strong></td>
<td></td>
<td>7. Identification Card for Use of Resident Citizen in the United States (Form I-179)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>10. School record or report card</td>
<td></td>
<td>8. Employment authorization document issued by the Department of Homeland Security</td>
</tr>
<tr>
<td></td>
<td></td>
<td>11. Clinic, doctor, or hospital record</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>12. Day-care or nursery school record</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

Refer to Section 2 of the instructions, titled "Employer or Authorized Representative Review and Verification," for more information about acceptable receipts.
**DIRECT DEPOSIT ENROLLMENT AUTHORIZATION**

**STATE OF CALIFORNIA - CONTROLLER'S OFFICE**

**COMPLETION INSTRUCTIONS AND PRIVACY NOTICE ARE ON THE REVERSE OF THE EMPLOYEE COPY. PLEASE TYPE OR USE BALL POINT PEN - PRINT CLEARLY.**

**SECTION A (To be completed by employee)**

<table>
<thead>
<tr>
<th>1. TYPE OF ENROLLMENT ACTION</th>
<th>2. SOCIAL SECURITY NUMBER</th>
</tr>
</thead>
<tbody>
<tr>
<td>NEW</td>
<td></td>
</tr>
<tr>
<td>CHANGE</td>
<td></td>
</tr>
<tr>
<td>CANCEL</td>
<td></td>
</tr>
</tbody>
</table>

3. NAME (First)  
Middle  
Last

**SECTION B (To be completed by employee if NEW or CHANGE box in Section A is checked)**

1. TYPE OF ACCOUNT - MUST BE CHECKED. IF LEFT BLANK, WILL BE PROCESSED AS CHECKING.

<table>
<thead>
<tr>
<th>C (Checking)</th>
<th>S (Savings)</th>
</tr>
</thead>
</table>

**Verify Routing/Depositor Numbers with Financial Institution**

2. ROUTING NUMBER  
3. DEPOSITOR ACCOUNT NUMBER

4. FINANCIAL INSTITUTION NAME

5. FINANCIAL INSTITUTION ADDRESS  
City  
State  
ZIP

**SECTION C (To be completed by employee if NEW or CHANGE box in Section A is checked)**

I hereby authorize the State Controller's Office to provide for direct deposit of any salary or wages due me, less any mandatory or authorized withholding or deductions therefrom, in the above designated account.

If at any time the amount of salary or wages so deposited exceeds the amount of salary or wages actually due and payable to me, I hereby authorize the State Controller's Office to either:

(a) Withhold a sum equal to the overpayment from future salary or wages; or

(b) Recover such overpayment from the above-designated account.

If the State is legally obligated to withhold any part of my wage or salary payment for any reason, or if I no longer meet eligibility requirements for the Direct Deposit program, I understand the State Controller's Office may terminate my enrollment in the program.

If any action taken by me results in nonacceptance of a direct deposit by the designated financial institution, I understand that the State assumes no responsibility for processing a supplemental salary payment until the amount of the nonacceptance deposit is returned to the State by the financial institution.

☐ 100% of the net deposit will not be sent to a financial institution outside the jurisdiction of the United States.

SIGNATURE:  
DATE:

**SECTION D (To be completed by employee if CANCEL box in Section A is checked)**

I hereby cancel my Direct Deposit authorization.

SIGNATURE:  
DATE:

**SECTION E (To be completed by state agency or campus personnel/payroll office only)**

1. AGENCY/CAMPUS NAME  
2. AGENCY CODE  
3. UNIT

4. REMARKS  
☐ CHECK BOX IF SEMI-MONTHLY EMPLOYEE

5. AUTHORIZED AGENCY/CAMPUS SIGNATURE

I HEREBY CERTIFY THAT I AM THE DULY APPOINTED, QUALIFIED AND ACTING OFFICER OF THE HEREBIN NAMED AGENCY/CAMPUS AND THAT, BEING SO AUTHORIZED, DO CERTIFY THAT THIS EMPLOYEE IS ELIGIBLE FOR DIRECT DEPOSIT.

☐ TELEPHONE NUMBER  
☐ CHECK IF CALM

DATE RECEIVED IN EMPLOYING OFFICE  
MO.  
DAY  
YR.
PLEASE READ THIS INFORMATION CAREFULLY

COMPLETION INSTRUCTIONS

1. To enroll in Direct Deposit, complete this form as follows:
   
   General Instructions
   • Complete Sections A, B and C if you are enrolling for the first time, re-enrolling after cancellation, or changing your existing Direct Deposit information.
   • Complete Section A and D only if you are cancelling your enrollment.

   Specific Instructions
   • Section A — (Item 1) Type of Enrollment Action
     New—Complete for new enrollment or re-enrollment after cancellation
     Change—Complete to change type of account, financial institution or branch (routing number), or depositor account number
     Cancel—Complete to cancel your Direct Deposit
   
   • Section B — (Item 1) Indicate checking OR savings. Only one box must be checked. If left blank, will be processed as checking.
     (Item 2) Enter Routing Number (cannot begin with a '5' and cannot exceed 9 digits)
     (Item 3) Enter Depositor Number (cannot exceed 17 digits)

   • Section C — According to National Clearing House Association Operating Rules, effective September 18, 2009, you are not allowed to forward 100% of your net payment to a financial institution outside of the United States (U.S.). If 100% of the net deposit is being sent outside the jurisdiction of the U.S., you are no longer allowed to participate in the Direct Deposit program and must cancel your enrollment. A paper warrant will be issued to you effective the month the cancellation is processed.
     For new/change enrollments, please mark the box indicating you are aware of this requirement and are not sending 100% of the net deposit outside the jurisdiction of the U.S.

   IMPORTANT: PLEASE VERIFY YOUR DEPOSITOR ACCOUNT NUMBER AND ROUTING NUMBER WITH YOUR FINANCIAL INSTITUTION.

2. Forward your completed form to your personnel/payroll office for completion of Section E.
3. Your first payment will be deposited into your designated account within 40 days after your form is received by the Controller's Office.

DIRECT DEPOSIT POSTING DATES

Funds for regular monthly or semi-monthly employees paid on the last day of the pay period should be available the first banking day after the end of the pay period. For example, if the pay period ends on a Wednesday, funds should be available on Thursday. If the pay period ends on a Friday, a weekend, or a holiday, funds should be available on the next banking day.

Funds for positive pay employees paid with a lag between the end of the pay period and pay day are available within two banking days after the issue date of the payment on the direct deposit earnings statement.

While most financial institutions post funds to accounts at the beginning of the bank business day, this is not a universal practice. Some institutions post funds in the afternoon instead of the morning. It is strongly recommended that you check with your financial institution to determine when your funds will be available.

CHANGING FINANCIAL INSTITUTION OR DEPOSITOR ACCOUNTS

Your Direct Deposit will continue to be deposited into your designated account at your financial institution until the State Controller’s Office is notified that you wish to redesignate your account and/or your financial institution. To redesignate, complete and submit a new STD. 699 with the new information. DO NOT CLOSE YOUR OLD ACCOUNT UNTIL YOUR FIRST PAYMENT IS DEPOSITED INTO YOUR NEWLY DESIGNATED ACCOUNT AND/OR FINANCIAL INSTITUTION. Your first payment into your new account will be within 40 days after your form is received by the Controller’s Office. You may receive a paper warrant during this period.

PRIVACY NOTICE

The Information Practices Act of 1977 (Civil Code Section 1798.17) and the Federal Privacy Act (Public Law 93-579) require that this notice be provided when collecting personal information from individuals. Information requested on this form is used by the State Controller’s Office for the purposes of identification and enrollment processing. It is mandatory to furnish all information requested on this form except for financial institution name, address and branch number or name. Failure to provide the mandatory information may result in the enrollment action not being processed or being processed incorrectly.

Legal references authorizing maintenance of this information include Government Code Sections 1151 and 1153, Sections 6011 and 6051 of the Internal Revenue Code, and Regulation 4, Section 404.1256, Code of Federal Regulations, under Section 218, Title II of the Social Security Act. Copies of the Enrollment Authorization are maintained in confidential files of the State Controller’s Office for six years. Employees have the right of access to copies of their Enrollment Authorization forms upon request. The official responsible for maintenance of the forms is: Chief of Personnel/Payroll Operations Branch, State Controller’s Office, P.O. Box 942850, Sacramento, California 94250-5878.
Direct Deposit Program Fact Sheet
for CMA Faculty, Staff and Students

WHAT IS DIRECT DEPOSIT?
Direct Deposit is a program that allows the automatic deposit of your net earnings in the financial institution of your choice.

HOW DO I SIGN UP FOR DIRECT DEPOSIT?
Complete the State’s Standard Form (STD) 699, Direct Deposit Enrollment Authorization Form available online at www.documents.dgs.ca.gov/osp/pdf/std699.pdf.

WHAT IS THE BANK ROUTING NUMBER AND ACCOUNT NUMBER REQUESTED ON THE “DIRECT DEPOSIT ENROLLMENT AUTHORIZATION” FORM?
These numbers are used to identify your financial institution and account. It is extremely important that this information be accurate – if not, your paycheck maybe deposited to the wrong account or the length of time to enroll in the program will be increased. IMPORTANT: PLEASE VERIFY YOUR DEPOSITOR ACCOUNT NUMBER AND ROUTING NUMBER WITH YOUR FINANCIAL INSTITUTION.

WHAT HAPPENS AFTER I SUBMIT THE ENROLMENT FORM?
The Payroll Office will complete the remainder of the form and forward it to the State Controller’s Office for processing. Once the State Controller’s Office verifies that you have an account at your designated financial institution, all paychecks will be made by Direct Deposit.

HOW LONG WILL IT TAKE FOR THE CHANGE TO OCCUR?
After the State Controller’s Office has received your form, you can expect the Direct Deposit of your paychecks to begin within one or two pay cycles (usually between 30-60 days).

HOW WILL I KNOW IF THE STATE CONTROLLER’S OFFICE HAS SENT MY PAYCHECK TO MY FINANCIAL INSTITUTION?
A Direct Deposit Advice (DDA) will be available for you to pick up in the Cashier’s Office.

CAN I HAVE MY PAYCHECKS DEPOSITED TO EITHER MY CHECKING OR SAVINGS ACCOUNT?
Yes. Either account is eligible. However, you must designate only one account to receive your funds. If you want a portion of your paycheck deposited into another account, you must make arrangements with your financial institution for a transfer of funds.

CAN I HAVE MY PAYCHECKS DEPOSITED TO MY SPOUSE’S ACCOUNT?
Not unless your name is also listed on the account. The account to which paycheck is deposited must have your name on it.

WHAT IF I LATER CHOOSE TO TRANSFER MY DIRECT DEPOSIT TO ANOTHER ACCOUNT OR FINANCIAL INSTITUTION?
To transfer your Direct Deposit, complete and submit a new enrollment form. IMPORTANT: KEEP YOUR OLD ACCOUNT OPEN UNTIL YOUR FIRST PAYCHECK IS DEPOSITED INTO YOUR NEW ACCOUNT. If your old account is closed before you notify the State Controller’s Office of the change, the paycheck will be rejected by the financial institution and a paycheck will not be issued, the paycheck returns to the Controller’s Office.
WHAT HAPPENS IF A PAYCHECK IS REJECTED BY MY FINANCIAL INSTITUTION BECAUSE OF A PROBLEM WITH THE ACCOUNT?
If a paycheck is rejected by your financial institution because of an invalid account number, the State Controller’s Office will notify the Payroll Office, take you off the Direct Deposit program, and issue a payroll warrant (usually within 10-17 working days after the State Controller’s Office has received the rejected paycheck).

WHAT HAPPENS IF I AM OVERPAID THROUGH DIRECT DEPOSIT?
If you receive an overpayment through Direct Deposit, the State has the option of either recovering the funds directly from the account you designated for Direct Deposit or recovering the funds from a future paycheck. If the State chooses to recover the overpayment from future salary warrants, it may be necessary to remove you from Direct Deposit.

AM I THE ONLY ONE WHO CAN CANCEL MY DIRECT DEPOSIT AUTHORIZATION?
No. The Payroll Office may remove you from Direct Deposit under the following conditions:
- Your Direct Deposit paycheck is returned (e.g., due to a closed account or invalid routing number); or
- It is necessary to recover/prevent an overpayment; or
- It is necessary to issue you a salary advance; or
- Under certain bankruptcy conditions.
You will be notified by the Payroll Office when such an action is taken.

WHAT HAPPENS TO MY PAY IF I HAVE MORE THAN ONE POSITION?
All salary payments (not travel or moving expenses, etc.) will be deposited into your designated account, regardless of the number of positions you have. Be sure to complete and submit only one enrollment form regardless of how many positions you have.

IF MY FUNDS ARE NOT DEPOSITED ON THE EXPECTED DATE, WHO SHOULD I CONTACT?
- If you received your Direct Deposit Advice, first contact your financial institution to be certain there is no delay in posting at that institution. Usually the problem can be resolved at this level.
- If your financial institution has not received your funds, or they were rejected due to a change in your account number, contact the Payroll Office (at extension 1712).
- If you haven’t received your Direct Deposit Advice, contact your department attendance representative, the Cashier’s Office, or Payroll.

DIRECT DEPOSIT POSTING DATES
- Funds for regular staff or faculty employees paid on the last day of the pay period should be available the first banking day after the end of the pay period. For example, if the pay period ends on a Wednesday, funds should be available on Thursday. If the pay period ends on a Friday, a weekend, or a holiday, funds should be available on the next banking day.
- Funds for positive pay employees (such as student and temporary employees) paid with a lag between the end of the pay period and pay day are available within two banking days after the issue date of the payment on the direct deposit earnings statement. While most financial institutions post funds to account at the beginning of the bank business day, this is not a universal practice. Some institutions post funds in the afternoon instead of the morning.
- It is strongly recommended that you check with your financial institution to determine when your funds will be available.
New Hire Notice -- Injuries Caused By Work

What does workers' compensation cover?

You may be entitled to workers' compensation benefits if you are injured or become ill because of your job. Workers' compensation covers most work-related physical or mental injuries and illnesses. An injury or illness can be caused by one event (such as hurting your back in a fall) or by repeated exposures such as hurting your wrist from doing the same motion over and over). Generally, independent contractors, and volunteers who receive no compensation are not covered by workers' compensation benefits. Injuries resulting from off duty recreational, social, or athletic activities, unless condoned or sponsored by your employer, are generally not covered.

Benefits:

Workers' compensation benefits include; Medical care, temporary disability, permanent disability, supplemental job displacement voucher, and death benefits.

Medical Care:

You are entitled to medical care that is reasonably required to care or relieve you from the effects of your work-related injury. Medical care may include doctor visits, hospital services, physical therapy, lab tests, x-rays, and medicines that are reasonably necessary to treat your injury. Providers should never bill you directly for work-related Injuries. There is a limit on some medical services. Your employer is required to provide you with a claim form within one business day of learning about your injury. It is extremely important that you complete the 'Employee' section of the claim form as your employer is required to authorize medical care within one working day after you file the form. If additional care is necessary after the initial treatment, the claims administrator will authorize any care that is appropriate for your injury, including the referral to specialists.

Your Primary Treating Physician (PTP):

This is the doctor with overall responsibility for treating your injury or illness. The primary treating physician determines what type of treatment you need and when you may return to work. A multispecialty medical group of licensed doctors and osteopathy can be designated as personal physicians. 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 by making a request to the claims administrator. Chiropractors may not continue as the primary treating physician after 24 visits. If specialists, diagnostics, etc. are needed in your care, this physician will be responsible for making the referrals. If you name your personal physician before your injury, you may see him or her for treatment in certain circumstances. Otherwise, your employer has the right to select the physician who will treat you for the first 30 days. You may be able to switch to a doctor of your choice after 30 days. Special rules apply if your employer offers a Health Care Organization (HCO) or has a medical provider network.

You should receive information from your employer if you are covered by an HCO or MHN. Contact your employer for more information.

Treatment by your personal physician:

You may be treated by your personal physician if you notify your employer prior to your injury. A personal physician includes a medical group of licensed, doctors of medicine or osteopathy. Please have your physician complete the attached form and return to your employer. The following requirements must be met:

1. You must have group health coverage from any source for non-industrial illnesses and injuries.
2. Your personal physician must agree in advance to treat you for any work injuries or illnesses.
3. Your physician must be your regular physician and surgeon.
4. Your physician has previously directed your medical treatment and retains your records, including your medical history.

What happens if your employer disputes your injury?

State law requires employers to authorize medical care within one working day of receiving a DWC 1 claim form. Your employer may be liable for as much as $10,000 in medical care until your claim is accepted or denied.

Medical Provider Networks:

Your employer may be using a MPN, which is a selected network of health care providers to provide treatment to workers injured on the job. If your employer is using a MPN, a MPN notice should be posted next to this poster to explain how to use the MPN. If you have pre-designated your personal physician prior to your work injury, then you may receive treatment from your pre-designated doctor. If you have not pre-designated and your employer is using a MPN, you are free to choose an appropriate provider from the MPN list after the first medical visit directed by the employer. If you are treating with a non-MPN doctor for an existing injury, you may be required to change to a doctor within the MPN.

What if my employer has a Medical Provider Network?

If your employer has Medical Provider Network additional information can be obtained by reviewing the full employee notification which is required to be posted in close proximity to the workers' compensation poster.

What if my employer does not have a Medical Provider Network?

If your employer 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 within 30 days of reporting your injury. Chiropractors may not continue as
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. Chiropractors may not continue as the primary treating physician after 24 visits.

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)

(telephone number)

Employee Name (please print): ________________________________

Employee's Address: _________________________________________

Employee's Signature: ________________________________________ Date: __________