# FEDERAL WORK STUDY PROGRAM
# STUDENT HIRING AGREEMENT

| | | |
|---|---|---|
| Student's Name | | |
| Student's Address | | |
| City | State | Zip |
| FWS Agency | | |
| FWS Agency Address | | |
| City | State | Zip |
| FWS Agency Contact | Email/Phone | |

| |
|---|
| Award Year **2023/2024** |
| Validity Period **07/01/2023 –06/30/2024** |
| Student ID |
| Phone |
| Total Award |
| Hourly Rate |
| Hiring Date / / |

This Agreement entered onto between **THOMAS JEFFERSON SCHOOL OF LAW**, hereinafter called the Institution, the Agency, and the student (as indicated above) for the purpose of enabling students to participate in the Federal Work-Study Program, hereinafter called the Program, through employment offered by the Agency under the terms stipulated within this agreement and the Federal Work Study Agency Agreement. The Student, Agency, and Institution herein incorporate by reference all of the terms and provisions stated in the Thomas Jefferson School of Law Federal Work Study Agency Agreement between the Agency and the Institution. This agreement shall terminate on the date stated above as the end date or the 30th of June **2024** whichever is earlier, unless sooner terminated according to the employing agency's student employment policies.

**Maximum Hours per week**: The students enrolled in the **Full-Time program of study may not work more than 20 hours per week** during the FALL or SPRING semesters. The students enrolled in the **Part-Time program of study may not work more than 29 hours per week** during the FALL or SPRING semesters. Students cannot work more than 8 hours in a day and must take a half-hour break if working over 6 hours. **Overtime is prohibited**. If funds permit, all students, regardless of program of enrollment, may work up to 29 hours per week during an inter-session, scheduled semester break, or during the SUMMER term. Employment under the Federal Work Study program in no way vitiates the necessity to comply with Bar regulations limiting students enrolled in the Full- Time Program of study to a maximum 20-hour work week while classes are in session.

A student must be enrolled at least half time during a regular semester (Fall or Spring) in order to be eligible for FWS employment. A student may be employed under FWS during a period of nonattendance, such as a summer or equivalent vacation period. To be eligible for this employment, the student must be planning to enroll for the next regular session (i.e. FALL). Earnings during this period of nonattendance will be considered as financial assistance used to pay the cost of attendance for the next period of enrollment. The student must sign a statement that certifies their intent to enroll in the upcoming Fall Semester if employed under FWS during a Summer Session in which they are not attending classes. (FWS Student Certification of Intent to Enroll)

The Student and Agency will put forth a good faith effort to monitor earnings while working for the agency so that the amount of eligibility awarded will not be exceeded.

In the event of injury on the job, Worker's Compensation Coverage will be the exclusive remedy of the student. The student will comply with the Agency's student employment policies.

| | |
|---|---|
| Student's Signature | Student's Name |
| Agency's Authorized Signature | Contact Name & Title |
| Student Finance Office Authorized Signature | Date SFO Processed Paperwork |
| Accounting Office Authorized Signature | Date |

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# FEDERAL WORK-STUDY ELIGIBILITY AUTHORIZATION

I, _____, understand that I will not begin working under the Federal Work-Study (FWS) program until all applicable FWS forms are turned in and approved by the Financial Aid Office. I acknowledge that I am not authorized or permitted to work prior to receiving approval by the Financial Aid Office.

Student Signature_____ Date_____

Supervisor Signature_____ Date_____

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# FEDERAL WORK-STUDY CONFIDENTIALITY POLICY

I understand that due to the nature of my Federal Work-Study job at Thomas Jefferson School of Law, I may become acquainted with all or various portions of student and/or business information and other matters which are of a proprietary nature to the school. I agree to keep confidential and shall not divulge to any student, staff, or faculty member, person or entity any of the confidential or proprietary information. Additionally, I may not divulge any salary information to any other employee, student or staff. Any questions regarding these requirements should be addressed to your immediate supervisor or Human Resources.

Failure to comply with the statement above will be a violation of the Family Educational Rights and Privacy Act (FERPA), enacted as section 438 of the General Education Provisions Act.

I understand that failure to comply with the statements above will subject me to disciplinary action up to and including termination and/or prosecution to the extent allowed by law.

Student Signature_____ Date_____

Supervisor Signature_____ Date_____

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# FEDERAL WORK-STUDY STUDENT RESPONSIBILITIES AND DOCUMENT CHECKLIST

***ATTENTION STUDENT:* The Federal Work Study (FWS) student employment program at TJSL is designed to help you earn a portion of your college expenses while you gain valuable work experience. You may not earn more than the amount listed on your financial aid award letter and/or Student Hiring Agreement.**

*Please read and initial that you have read and understand the following:*

_____ *I understand that I must maintain satisfactory academic progress, as defined in the TJSL Student Handbook, in order to participate in the FWS program. My employment may be terminated if my GPA falls below 2.0 and/or upon graduation, withdrawal or dismissal from TJSL. I must be enrolled at least half-time status during Fall and Spring Semesters.*

_____ *I understand that I may be employed under FWS during a period of nonattendance, such as a summer or equivalent vacation period. To be eligible for this employment, I must be planning to enroll for the next regular session (ie. FALL). My earnings during this period of non-attendance will be considered as financial assistance used to pay my cost of attendance for the next period of enrollment.*

_____ *I understand that this is an employment opportunity and that I will be paid only for hours actually worked. In addition, I understand that I may not work for more than the maximum hours per week as specified on the Hiring Agreement*

_____ *I understand that it is my responsibility to coordinate my work schedule with my supervisor and to meet this schedule to the best of my ability and if I am unable to work, I will be expected to notify my supervisor in advance.*

_____ *I understand that at no time may I work more than the number of hours indicated on my hiring agreement and that I am required to take at least a half hour break if working more than 6 hours per day. I cannot work more than 8 hours in a day, over 29 hours in a week, and 7 consecutive days during a work week.*

_____ *I understand that it is my responsibility to monitor my earnings to avoid exceeding the amount of my award. I also understand that I may NOT be paid for hours that exceed my award amount.*

_____ *I understand that I will be paid bi-weekly. It is my responsibility to complete my time sheet, including all required signatures and submit it to the Financial Assistance Office by noon on or before the required date. If my time sheet is completed incorrectly/inaccurately or submitted late, I may not be paid until the following pay period.* ***(No Exceptions)***

_____ *I understand that I cannot get paid for hours worked prior to submitting a completed FWS student packet.*

_____ *I understand that a FWS position is a JOB. I should give my employer a two week notice prior to resigning my position. I further understand that I may be discharged by my employer for poor performance, misconduct, excessive absences, tardiness, or at will.*

***My signature below certifies that I have read, understood, and agree to the above statements.***

***Signature:*** _____ ***Date:*** _____

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# MEAL PERIOD WAIVER

**First Meal Period**

I understand that employees who work more than five (5) hours in a day are provided a 30-minute, uninterrupted unpaid meal period that must be started before the completion of the fifth hour of work. However, where the employee does not work more than six (6) hours in the workday, TJSL and the employee may mutually agree to waive the meal period.

Accordingly, I agree to waive the meal period provided to me whenever my total day's work will be more than five (5) hours, but completed within six (6) hours.

**Second Meal Period**

I understand that employees who work more than ten (10) hours in a day are provided a second 30-minute, uninterrupted unpaid meal period that must be started before the completion of the tenth hour of work. However, where the employee does not work more than twelve (12) hours in the workday, TJSL and the employee may mutually agree to waive the second meal period so long as the first meal period was taken.

Accordingly, I agree to waive the second meal period provided to me whenever my total day's work will be more than ten (10) but no more than twelve (12) hours, and I took the first meal period.

**I enter into this agreement freely and voluntarily. I understand that this agreement can be revoked in writing by either me or TJSL at any time.**

_____ _____

Employee (Please Print) Date

_____

Employee Signature

_____

Supervisor Signature

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## MEAL AND REST BREAKS

All employers must provide a meal break of at least one half-hour for every work period of more than five hours. However, if six hours of work will complete the day's work, the employee may voluntarily choose not to take the meal break by completing a Meal Period Waiver. For every four hours worked, a rest break of 10 minutes must be taken. Breaks are not recorded on a timesheet.

## TIMEKEEPING

Federal and State laws require the employer to keep accurate records of time worked in order to calculate Employee pay and benefits. *Time worked* is all the time actually spent on the job performing assigned duties. To comply with Federal and State wage and hour laws, all Federal Work Study employees will be given a timesheet to complete according to the payroll schedule. It is your responsibility to record each day, the time you start work, begin and end your meal period, and end work. Your timesheet includes the number of hours worked and any adjustments (such as overtime, absence and vacation, if applicable) that occur during each pay period.

At the end of each week, you are required to confirm your timesheet certifying that all hours of work have been accurately recorded, and all rest and meal breaks have been taken in accordance with School policy. Timesheets must be completed no later than the end of business on the last day of the pay period. Your timesheet is the record from which you are paid. Your timesheet must then be verified and approved by your Manager or Supervisor.

Under no circumstances may you record time on another Employee's timesheet. You must complete only your own timesheet. If you make an error when completing your time card or time sheet, you must notify your Manager or Supervisor. **Any Employee who violates or disregards this procedure, or any other procedures mentioned herein, may be subject to disciplinary action, up to and including termination.**

## TIMESHEET DEADLINES

Timesheets are due by 10:00 a.m. on Mondays following the end of each pay period (Monday of the scheduled pay day week). Should that Monday fall on a designated holiday, timesheets are due by 10:00 a.m. on the prior Friday.

## TIMESHEET APPROVALS

An authorized agency signer must approve each timesheet. Thomas Jefferson will verify that the supervisor is an authorized agency signer and the sign off is the official signature of the Employee and the Manager or Supervisor that the hours are correctly recorded. Your timesheet is an official, legal document and a personal certification of all hours worked and therefore must be accurately maintained. Falsifying or altering your time card or timesheet may result in disciplinary action, including termination of employment.

_____

***Signature of FWS Recipient*** ***Date***

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# Federal Work Study Program
# Personnel Data

**Please handprint this form using UPPER case letters.**

LAST NAME | FIRST NAME | M.I.

STREET ADDRESS | UNIT/APT

CITY | STATE | ZIP

HOME PHONE | CELL PHONE

SOCIAL SECURITY NUMBER | DATE OF BIRTH

MARTIAL STATUS | GENDER

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# *ELECTRONIC FUNDS TRANSFER (EFT)
# ENROLLMENT AUTHORIZATION

| Name (Print): | Employee No. (HR use only) |
|---|---|
| Last First Last 4 digits SSN | |

**Code:** A = Add C = Change D = Delete **Acct Type:** C = Checking S = Saving

| Code | Acct. Type | Amount or blank for full pay | Bank Routing Number | Bank Account Number | Bank Name |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |

☐ Check this box to cancel all EFT transactions

*"I authorize the School to make payments of my net pay by initiating credit entries or correcting entries to the bank accounts I've designated above.*

*I understand that this authorization will continue in force unless discontinued by my written request, and it is also my responsibility to maintain the designated account as open to prevent rejected or returned entries."*

*Signature* *Date*

** New account set up and review process will take 2-3 pay cycles to complete. During that time you will receive a regular pay check.*

**ACCOUNT VERIFICATION DOCUMENT FROM YOUR FINANCIAL INSTITUTION**

**OR VOIDED CHECK**

**MUST BE ATTACHED HERE TO PROCESS**

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# EMERGENCY MEDICAL DATA FORM

*(all information is voluntary and kept confidential)*

Name: _____ Date: _____

Date of Birth: _____

**In case of emergency, please contact:**

**Primary:**

Name: _____ Relationship: _____

Mobile phone: _____ Home phone: _____

Address: _____

_____

**Secondary:**

Name: _____ Relationship: _____

Mobile phone: _____ Home phone: _____

Address: _____

_____

**I am allergic to the following medications:**

_____

_____

_____

**I have the following pre-existing conditions that a doctor should be notified of:**

_____

_____

_____

# Employment Eligibility Verification

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

**USCIS**
**Form I-9**
OMB No.1615-0047
Expires 07/31/2026

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

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

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

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

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

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

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

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

- ☐ 1. A citizen of the United States
- ☐ 2. A noncitizen national of the United States (See Instructions.)
- ☐ 3. A lawful permanent resident (Enter USCIS or A-Number.)
- ☐ 4. A noncitizen (other than **Item Numbers 2.** and **3.** above) authorized to work until (exp. date, if any)

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

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

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

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

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

| | List A | OR | List B | AND | List C |
|---|---|---|---|---|---|
| **Document Title 1** | | | | | |
| Issuing Authority | | | | | |
| Document Number (if any) | | | | | |
| Expiration Date (if any) | | | | | |
| **Document Title 2 (if any)** | | | **Additional Information** | | |
| Issuing Authority | | | | | |
| Document Number (if any) | | | | | |
| Expiration Date (if any) | | | | | |
| **Document Title 3 (if any)** | | | | | |
| Issuing Authority | | | | | |
| Document Number (if any) | | | | | |
| Expiration Date (if any) | | | ☐ Check here if you used an alternative procedure authorized by DHS to examine documents. | | |

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

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

| Employer's Business or Organization Name | Employer's Business or Organization Address, City or Town, State, ZIP Code |
|---|---|
| **Thomas Jefferson School of Law** | **701 B Street, Suite 110. San Diego, CA 92101** |

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

# LISTS OF ACCEPTABLE DOCUMENTS

All documents containing an expiration date must be unexpired.
* Documents extended by the issuing authority are considered unexpired.
Employees may present one selection from List A or a
combination of one selection from List B and one selection from List C.
**Examples of many of these documents appear in the Handbook for Employers (M-274).**

| LIST A<br>**Documents that Establish Both Identity and Employment Authorization** | OR | LIST B<br>**Documents that Establish Identity** | AND | LIST C<br>**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:<br>**(1)** NOT VALID FOR EMPLOYMENT<br>**(2)** VALID FOR WORK ONLY WITH INS AUTHORIZATION<br>**(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 an individual temporarily authorized to work for a specific employer because of his or her status or parole:<br>**a.** Foreign passport; and<br>**b.** Form I-94 or Form I-94A that has the following:<br>**(1)** The same name as the passport; and<br>**(2)** An endorsement of the individual's status or parole 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<br>For examples, see **Section 7** and **Section 13** of the M-274 on **uscis.gov/i-9-central**.<br>The Form I-766, Employment Authorization Document, is a List A, **Item Number 4.** document, not a List C document. |
| **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 | | **For persons under age 18 who are unable to present a document listed above:** | | |
| | | **10.** School record or report card | | |
| | | **11.** Clinic, doctor, or hospital record | | |
| | | **12.** Day-care or nursery school record | | |

## Acceptable Receipts

May be presented in lieu of a document listed above for a temporary period.
For receipt validity dates, see the M-274.

| | | | |
|---|---|---|---|
| • Receipt for a replacement of a lost, stolen, or damaged List A document.<br>• Form I-94 issued to a lawful permanent resident that contains an I-551 stamp and a photograph of the individual.<br>• Form I-94 with "RE" notation or refugee stamp issued to a refugee. | OR | Receipt for a replacement of a lost, stolen, or damaged List B document. | Receipt for a replacement of a lost, stolen, or damaged List C document. |

*Refer to the Employment Authorization Extensions page on **I-9 Central** for more information.

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 |

EDD Employment Development Department
State of California

# 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<br><br>City State ZIP Code | Filing Status<br>☐ Single or Married (with two or more incomes)<br>☐ Married (one income)<br>☐ Head of Household |

1. Use Worksheet A for Regular Withholding allowances. Use other worksheets on the following pages as applicable.
   - 1a. Number of Regular Withholding Allowances (Worksheet A) ____
   - 1b. Number of allowances from the Estimated Deductions (Worksheet B, if applicable.) ____
   - 1c. Total Number of Allowances you are claiming ____
2. Additional amount, if any, you want withheld each pay period (if employer agrees), **(Worksheet C)**

OR

**Exemption from Withholding**

3. I claim exemption from withholding for 2023, and I certify I meet both of the conditions for exemption. (Check box 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 |
|---|---|
| Thomas Jefferson School of Law<br>701 B Street, Suite #110<br>San Diego, CA 92101 | 417-9520-4 |

**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 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 withholding 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) (edd.ca.gov/pdf_pub_ctr/de44.pdf) provides the income tax withholding tables. This publication may be found by visiting Payroll Taxes - 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** FTB (ftb.ca.gov).

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**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) (govt.westlaw.com/calregs/Search/Index), 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 (leginfo.legislature.ca.gov/faces/codes.xhtml) and section 19176 of the Revenue and Taxation Code (leginfo.legislature.ca.gov/faces/codes).xhtml).

# Worksheets

**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 1a of the DE 4 | (F) 0 |

**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 $10,404 if married filing joint with two or more allowances, unmarried head of household, or qualifying widow(er) with dependent(s) or $5,202 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. 0.00 |
| 4. | Enter an estimate of your adjustments to income (alimony payments, IRA deposits) | + 4. |
| 5. | Add line 4 to line 3, enter sum | = 5. 0.00 |
| 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. 0.00 |
| 8. | Divide the amount on line 7 by $1,000, round any fraction to the nearest whole number enter this number on line 1b of the DE 4. Complete Worksheet C, if needed, otherwise **stop here**. | 8. 0.00 |
| 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. 0.00 |
| 11. | Subtract line 10 from line 9, enter difference. Then, complete Worksheet C. | 11. 0.00 |

*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 2023. | 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. 0.00 |
| 8. | Figure your tax liability for the amount on line 7 by using the 2023 tax rate schedules below. | 8. |
| 9. | Enter personal exemptions (line F of Worksheet A x $154.00). | 9. 0.00 |
| 10. | Subtract line 9 from line 8. Enter difference. | 10. 0.00 |
| 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. 0.00 |
| 13. | Calculate the tax withheld and estimated to be withheld during 2023. 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 2023. 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 2023. | 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. 0.00 |
| 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 2023 Only*

**Single Persons, Dual Income Married or Married With Multiple Employers**

| IF THE TAXABLE INCOME IS | | COMPUTED TAX IS | | |
|---|---|---|---|---|
| OVER | BUT NOT OVER | OF AMOUNT OVER... | | PLUS |
| $0 | $10,099 | 1.100% | $0 | $0.00 |
| $10,099 | $23,942 | 2.200% | $10,099 | $111.09 |
| $23,942 | $37,788 | 4.400% | $23,942 | $415.64 |
| $37,788 | $52,455 | 6.600% | $37,788 | $1,024.86 |
| $52,455 | $66,295 | 8.800% | $52,455 | $1,992.88 |
| $66,295 | $338,639 | 10.230% | $66,295 | $3,210.80 |
| $338,639 | $406,364 | 11.330% | $338,639 | $31,071.59 |
| $406,364 | $677,275 | 12.430% | $406,364 | $38,744.83 |
| $677,275 | $1,000,000 | 13.530% | $677,275 | $72,419.07 |
| $1,000,000 | and over | 14.630% | $1,000,000 | $117,556.49 |

**Unmarried Head of Household**

| IF THE TAXABLE INCOME IS | | COMPUTED TAX IS | | |
|---|---|---|---|---|
| OVER | BUT NOT OVER | OF AMOUNT OVER... | | PLUS |
| $0 | $20,212 | 1.100% | $0 | $0.00 |
| $20,212 | $47,887 | 2.200% | $20,212 | $222.33 |
| $47,887 | $61,730 | 4.400% | $47,887 | $831.18 |
| $61,730 | $76,397 | 6.600% | $61,730 | $1,440.27 |
| $76,397 | $90,240 | 8.800% | $76,397 | $2,408.29 |
| $90,240 | $460,547 | 10.230% | $90,240 | $3,626.47 |
| $460,547 | $552,658 | 11.330% | $460,547 | $41,508.88 |
| $552,658 | $921,095 | 12.430% | $552,658 | $51,945.06 |
| $921,095 | $1,000,000 | 13.530% | $921,095 | $97,741.78 |
| $1,000,000 | and over | 14.630% | $1,000,000 | $108,417.63 |

**Married Persons**

| IF THE TAXABLE INCOME IS | | COMPUTED TAX IS | | |
|---|---|---|---|---|
| OVER | BUT NOT OVER | OF AMOUNT OVER... | | PLUS |
| $0 | $20,198 | 1.100% | $0 | $0.00 |
| $20,198 | $47,884 | 2.200% | $20,198 | $222.18 |
| $47,884 | $75,576 | 4.400% | $47,884 | $831.27 |
| $75,576 | $104,910 | 6.600% | $75,576 | $2,049.72 |
| $104,910 | $132,590 | 8.800% | $104,910 | $3,985.76 |
| $132,590 | $677,278 | 10.230% | $132,590 | $6,421.60 |
| $677,278 | $812,728 | 11.330% | $677,278 | $62,143.18 |
| $812,728 | $1,000,000 | 12.430% | $812,728 | $77,489.67 |
| $1,000,000 | $1,354,550 | 13.530% | $1,000,000 | $100,767.58 |
| $1,354,550 | and over | 14.630% | $1,354,550 | $148,738.20 |

If you need information on your last California Resident Income Tax Return, FTB Form 540, visit (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.

# NOTICE TO EMPLOYEE

***Labor Code section 2810.5***

## EMPLOYEE

Employee Name: _____

Start Date: _____

## EMPLOYER

Legal Name of Hiring Employer: THOMAS JEFFERSON SCHOOL OF LAW

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):

N/A

Physical Address of Hiring Employer's Main Office:

701 B STREET, SUITE #110, SAN DIEGO. CALIFORNIA 92101

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

SAME AS ABOVE

Hiring Employer's Telephone Number: 619-297-9700

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: 16.30 Overtime Rate(s) of Pay: 24.45

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):

N/A

(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: BI-WEEKLY, EVERY OTHER FRIDAY

**WORKER'S COMPENSATION**

Insurance Carrier's Name: ZENITH INSURANCE COMPANY

Address: 21255 CALIFA STREET, WOODLAND HILLS, CA. 91367-5021

Telephone Number: 800-440-5020

Policy No.: C134696906

☐ 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.

# New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 7-31-2023)

## PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

### What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

### Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

### Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

**Note:** If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution -as well as your employee contribution to employer-offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

### How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact Human Resources Department, 619-961-4326

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit **HealthCare.gov** for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

[1] An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

# PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

| 3. Employer name | 4. Employer Identification Number (EIN) |
|---|---|
| Thomas Jefferson School of Law | 33-069561 |
| 5. Employer address<br>701 B Street, Suite #110 | 6. Employer phone number<br>619-297-9700 |

| 7. City | 8. State | 9. ZIP code |
|---|---|---|
| San Diego | CA | 92101 |

| 10. Who can we contact about employee health coverage at this job? | |
|---|---|
| Lisa Chigos | |
| 11. Phone number (if different from above)<br>619-961-4326 | 12. Email address<br>lchigos@tjsl.edu |

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:

☐ All employees. Eligible employees are:

☑ Some employees. Eligible employees are:

All Regular, full-time employees, regularly scheduled and working 30 or more hours each week.

- With respect to dependents:

☑ We do offer coverage. Eligible dependents are:

Spouse or Domestic Partner. Your children, your spouse's children and your domestic partner's eligible children to age 26.

☐ We do not offer coverage.

☑ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, **HealthCare.gov** will guide you through the process. Here's the employer information you'll enter when you visit **HealthCare.gov** to find out if you can get a tax credit to lower your monthly premiums.

The information below corresponds to the Marketplace Employer Coverage Tool. Completing this section is optional for employers, but will help ensure employees understand their coverage choices.

13. **Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?**

☐ **Yes** (Continue)
13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage?_____ (mm/dd/yyyy) (Continue)
☑ **No** (STOP and return this form to employee)

14. Does the employer offer a health plan that meets the minimum value standard*?
☐ Yes (Go to question 15) ☐ No (STOP and return form to employee)

15. For the lowest-cost plan that meets the minimum value standard* **offered only to the employee** (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.
a. How much would the employee have to pay in premiums for this plan? $_____
b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and return form to employee.

16. What change will the employer make for the new plan year?_____
☐ Employer won't offer health coverage
☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)
a. How much would the employee have to pay in premiums for this plan? $_____
b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

* An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

TheZenith®
A FAIRFAX Company

## California Employers Must Provide This Notice to Employees at Time of Hire

# Time of Hire Notice

# Notificación de Nuevo Empleado

**TABLE OF CONTENTS**



**ÍNDICE**

**Notice to Employees**
**(Pursuant to LC §3551 and 8 CCR §9880)**

**What is Workers' Compensation?**
Workers' compensation is insurance paid for by your employer. It pays your medical bills for reasonably medically necessary care to treat a work related injury or illness and provides money to help replace any lost wages if you are unable to return to work.

**Workers' Compensation Insurance Carrier and Claims Administrator:** Your employer has obtained workers' compensation insurance from either Zenith Insurance Company or ZNAT Insurance Company (Zenith).

**Zenith's Mailing Address:**
Zenith
P.O. Box 9055
Van Nuys, CA 91409-9055

**Claims Administration for Both Companies is Performed by Zenith Insurance Company:**
Zenith toll free number: 800-440-5020
ZMPN website: www.TheZenith.com

**What Types of Injuries and Illnesses are Covered?**
The injury or illness can be caused by one event like a fall, or repeated exposures, such as repetitive motion over time. Workers' compensation covers many types of injuries – including physical or psychiatric injuries resulting from a workplace crime. However, the insurance does not cover injuries requiring only first aid. Your employer may not be liable for the payment of workers' compensation benefits for any injury that arises from your voluntary participation in any off-duty, recreational, social, or athletic activity that is not part of your work-related duties.

**Who's Covered?**
Almost every employee in California is protected by workers' compensation, but there are a few exceptions. People in business for themselves and unpaid volunteers may not be covered. Maritime workers and federal employees are covered by similar laws. If you have a question about coverage, ask your employer.

**What are the Benefits?**

- Medical Care: Doctor visits, hospital services, physical therapy, lab tests, x-rays, and medicines that are reasonably necessary to treat your injury. You should never see a bill. There is a limit on some medical services.
- Temporary Disability (TD) Benefits: Payments if you lose wages while recovering. For most injuries, TD benefits may not be paid for more than 104 weeks within five years from the date of injury. State Disability (Employment Development Department) benefits may be paid if TD benefits are delayed, denied or terminated.
- Permanent Disability (PD) Benefits: Payments if your injury causes a permanent disability.
- Supplemental Job Displacement Benefit: For dates of injury between 1/1/04 and 12/31/12, a nontransferable voucher payable to a state approved school if your injury results in a permanent disability that prevents you from returning to work within 60 days after TD ends, and your employer does not offer you modified or alternative work.
- For dates of injury on or after 1/1/13, a nontransferable voucher for education-related training costs and expenses if your injury results in a permanent disability and your employer does not offer you regular, modified or alternative work within 60 days from your permanent and stationary date.
- Death Benefits (DB): Paid to dependents of a worker who dies from a work-related injury or illness. A burial allowance is also paid. The amount of burial allowance will vary depending on the date of injury.
- Frequency of TD, PD and DB benefits: These benefits are paid every two weeks at 2/3 the average weekly wage with maximum and minimum limits set by law.
- Return to Work Benefit: If your injury results in a permanent disability and the state determines that your PD benefit is too low compared to your loss of future earning capacity, you may qualify for additional money

from the Department of Industrial Relation's Return to Work Fund. If you have questions or think you qualify, contact the Information & Assistance listed below or visit the DIR web site at www.dir.ca.gov.

**Naming Your Own Physician Before Injury or Illness (Predesignation):**
You may be able to choose the doctor who will treat you for a job injury or illness. If eligible, you must tell your employer, in writing, the name and address of your personal physician or medical group before you are injured and your physician must agree to treat you for your work injury. For instructions see the written information about workers' compensation that your employer is required to give to new employees.

**If You Get Hurt:**

1. **Get Medical Care.** If you need emergency care, call 911 for help immediately from the hospital, ambulance, fire department or police department and have your employer contact Zenith at 800-440-5020. If you need first aid, contact your employer.
2. **Report Your Injury.** Report the injury immediately to your supervisor or to an employer representative. Don't delay. There are time limits. If you wait too long, you may lose your right to benefits. Your employer is required to provide you a claim form within one working day after learning about your injury. Within one working day after you file a claim form, your employer shall authorize the provision of all treatment, consistent with the applicable treating guidelines, for your alleged injury and shall be liable for up to ten thousand dollars ($10,000) in treatment until the claim is accepted or rejected.
3. **See Your Primary Treating Physician (PTP).** This is the doctor with overall responsibility for treating your injury or illness. If you predesignated by naming your personal physician or medical group before injury (see Naming Your Own Physician Before Injury or Illness above), 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. Different rules apply if your employer offers a Health Care Organization (HCO) or has a Medical Provider Network (MPN). Your employer currently uses the Zenith Medical Provider Network. Contact Zenith at the number below or your employer for more information.
4. **Select a Provider from the Zenith Medical Provider Network.** Your employer is currently participating in the Zenith Medical Provider Network (ZMPN), which is a selected network of health care providers to provide treatment to workers injured on the job. You can request a copy of the ZMPN notice by calling Zenith at the number below or can download a copy at the website listed below. If you have predesignated a personal physician or medical group in writing prior to your work injury, then you may receive treatment from your predesignated physician or medical group. If you have not predesignated, you may choose an appropriate provider from the ZMPN list after the first medical visit directed by your employer. If you are treating with a non-ZMPN doctor for an existing injury, you may be required to change to a doctor within the ZMPN. You may obtain a ZMPN directory by calling Zenith toll free at 800-440-5020, online at www.TheZenith.com or through your employer. No passcode is required to access the directory. Click on the LOCATE button at the bottom of the web page to access the directory. Once in the directory, you may search for a provider by address, name or region. If you have questions about the ZMPN or how to access care for a work-related injury contact either your Zenith claims examiner or a ZMPN Medical Access Assistant. A Medical Access Assistant may be contacted by calling the toll free number listed below and choosing Medical Access Assistant from the menu:

   Toll Free Number: 800-440-5020
   Hours: Monday through Saturday, from 7:00 a.m. to 8:00 p.m. Pacific Time

   Providers are included in the ZMPN by either individual name or as a group/clinic. If a provider or group is not listed by name, it is not included in the ZMPN. Additionally, providers, medical groups and clinics are listed by location. Only those locations listed in the ZMPN directory are in the ZMPN. Services provided by a non-listed provider or at any office location not listed in the ZMPN directory are out of network and subject to denial.
5. **Select a Pharmacy from the Zenith Pharmacy Network.** Zenith provides pharmaceutical services through the Zenith Pharmacy Network (ZPN). All prescriptions for accepted work-related injuries must be obtained through a participating ZPN pharmacy. Bills for prescriptions obtained outside of the ZPN may be denied. Provider offices are not included in the ZPN and medications dispensed from a provider's office will not be reimbursed unless the dispensed medication is for a medically necessary:

- antiviral
- antibiotic; or
- intrathecal pain pump (including refill)

Prescriptions for antiviral and antibiotics filled by a pharmacy are required to be dispensed by a participating ZPN pharmacy. If you have any questions about how to obtain prescribed medications, call Zenith's pharmacy network benefits manager, Cadence Rx, toll-free at 888-813-0023. To use the ZPN online pharmacy locator tool, visit https://cadencerx.com/find-a-pharmacy/.

**Discrimination.** It is illegal for your employer to punish or fire you for having a work injury or illness, for filing a claim, or testifying in another person's workers' compensation case. If proven, you may receive lost wages, job reinstatement, increased benefits, and costs and expenses up to limits set by the state.

**Questions?** Learn more about workers' compensation by reading the information that your employer is required to give you at time of hire. If you have questions, see your employer or the claims administrator (who handles workers' compensation claims for your employer):
**Claims Administrator:** Zenith Insurance Company
**ZMPN Identification Number:** 3142
**Toll Free Number:** 800-440-5020
**Carrier/Self-Insured:** Zenith Insurance Company or ZNAT Insurance Company
**Policy Expiration Date:** December 31, 2023

If the workers' compensation policy has expired, contact a Labor Commissioner at the Division of Labor Standards Enforcement (DLSE).

You can also get free information about workers' compensation from a State Division of Workers' Compensation Information & Assistance Officer. The nearest Information & Assistance Officer can be found on the attached list or at www.dir.ca.gov/dwc/IandA.html or you may call toll-free at 800-736-7401. You can learn information about DWC and DLSE online at: www.dwc.ca.gov or www.dir.ca.gov/dlse.

**Your employer may not be liable for the payment of workers' compensation benefits for any injury that arises from your voluntary participation in any off-duty, recreational, social, or athletic activity that is not part of your work-related duties.**

## WORKERS' COMPENSATION FRAUD IS A FELONY

Anyone who makes or causes to be made any knowingly false or fraudulent material statement for the purpose of obtaining or denying workers' compensation benefits or payment is guilty of a felony. The penalty imposed if found guilty of fraud includes up to $150,000 in fines and imprisonment up to five years.

**The following is a list of the locations and telephone numbers of information and assistance officers. This list is also available online at www.dir.ca.gov/DWC/ianda.html**

| | | | |
|---|---|---|---|
| Anaheim<br>1065 N. PacifiCenter Drive<br>Anaheim 92806-2141<br>714-414-1801 | Bakersfield<br>1800 30th Street, Suite 100<br>Bakersfield, CA 93301-1929<br>661-395-2514 | Eureka<br>409 K Street, Room 201<br>Eureka, CA 95501-0481<br>707-441-5723 | Fresno<br>2550 Mariposa Mall, Room 5005<br>Fresno, CA 93721-2219<br>559-445-5355 |
| Long Beach<br>300 Oceangate Street, Suite 200<br>Long Beach, CA 90802-4304<br>562-590-5240 | Los Angeles<br>320 W. 4th Street, 9th floor<br>Los Angeles, CA 90013-1954<br>213-576-7389 | Marina del Rey<br>4720 Lincoln Blvd, 2nd floor<br>Marina del Rey, CA 90292-6902<br>310-482-3820 | Oakland<br>1515 Clay Street, 6th floor<br>Oakland, CA 94612-1519<br>510-622-2861 |
| Oxnard<br>1901 N. Rice Ave., Suite 200<br>Oxnard, CA 93030-7912<br>805-485-3528 | Pomona<br>732 Corporate Center Drive<br>Pomona, CA 91768-2653<br>909-623-8568 | Redding<br>250 Hemsted Drive, 2nd floor, Suite B<br>Redding, CA 96002-9040<br>530-225-2047 | Riverside<br>3737 Main Street, Room 300<br>Riverside, CA 92501-3337<br>951-782-4347 |
| Sacramento<br>160 Promenade Circle, Suite 300<br>Sacramento, CA 95834-2962<br>916-928-3158 | Salinas<br>1880 North Main St., Suite 100<br>Salinas, CA 93906-2037<br>831-443-3058 | San Bernardino<br>464 W. Fourth Street, Suite 239<br>San Bernardino, CA 92401-1411<br>909-383-4522 | San Diego<br>7575 Metropolitan Drive, Suite 202<br>San Diego, CA 92108-4424<br>619-767-2082 |
| San Francisco<br>455 Golden Gate Ave., 2nd floor<br>San Francisco, CA 94102-7014<br>415-703-5020 | San Jose<br>100 Paseo de San Antonio, Rm 241<br>San Jose, CA 95113-1402<br>408-277-1292 | San Luis Obispo<br>4740 Allene Way, Suite 100<br>San Luis Obispo, CA 93401-8736<br>805-596-4159 | Santa Ana<br>2 MacArthur Place, Suite 600<br>Santa Ana, CA 92707-7704<br>714-942-7576 |
| Santa Barbara<br>130 E. Ortega Street<br>Santa Barbara, CA 93101-7538<br>805-568-1295 | Santa Rosa<br>50 "D" Street, Room 420<br>Santa Rosa, CA 95404-4771<br>707-576-2452 | Stockton<br>31 E. Channel Street, Room 344<br>Stockton, CA 95202-2314<br>209-948-7980 | Van Nuys<br>6150 Van Nuys Blvd., Room 105<br>Van Nuys, CA 91401-3370<br>818-901-5367 |

## ADDITIONAL INFORMATION & RESOURCES

Visit TheZenith.com:

- To watch a video about healing
- To obtain a complete list of ZMPN providers in your area
- To read more about the claim process

If you need to speak to someone regarding the ZMPN, call Zenith's Provider Group at 800-440-5020. To find a participating pharmacy visit https://cadencerx.com/find-a-pharmacy/.

**If you have any questions about this notice, how to complete the forms, or how to access medical care, please contact your employer or call Zenith at 800-440-5020.**

**Aviso a los empleados—Lesiones causadas por accidentes laborales conforme a LC, Sección 3551 y 8 CCR, Sección 9880**

**¿Qué es la Compensación de los trabajadores por accidentes laborales?**
La compensación para trabajadores por accidentes laborales es un seguro pagado por su empleador. Paga las cuentas médicas por el cuidado médico razonablemente necesario para el tratamiento de cualquier lesión o enfermedad profesional por cuestiones laborales y le proporciona dinero para cubrir la pérdida de salario si no puede regresar a trabajar.

**Compañía de seguros para la compensación de los trabajadores por accidentes laborales y el Administrador de la reclamación:** Su empleador ha obtenido un seguro para la compensación de los trabajadores por accidentes laborales de la compañías: Zenith Insurance Company o de ZNAT Insurance Company (Zenith).

**Dirección postal de Zenith:**
Zenith
P.O. Box 9055
Van Nuys, CA 91409-9055

**Zenith Insurance Company lleva la administración de las reclamaciones para ambas compañías:**
Número gratuito de Zenith: 800-440-5020
Sitio web ZMPN: www.TheZenith.com

**¿Qué tipo de lesiones y enfermedades profesionales están cubiertas?**
La lesión o la enfermedad profesional pueden causarse en el evento de una caída o exposición continuada, así como un movimiento repetitivo con el paso del tiempo. El seguro de compensación de los trabajadores por accidentes laborales cubre muchos tipos de lesiones – incluyendo lesiones físicas y siquiátricas – como resultado de un crimen en el lugar de trabajo. Sin embargo, el seguro no cubre las lesiones que solo requieren primeros auxilios. Su empleador no se hará responsable de los pagos de los beneficios del seguro de los trabajadores por accidentes laborales de toda lesión que pudiera resultar por su participación voluntaria en una actividad fuera del trabajo, recreacional, social o deportiva que no esté relacionada con sus obligaciones laborales.

**¿Quién está cubierto?**
Casi la mayoría de los empleados de California están protegidos por el seguro de compensación de los trabajadores por accidentes laborales pero existen ciertas restricciones. Las personas que hacen negocios o voluntarios que no están pagados puede que no estén cubiertos. Los trabajadores marítimos y los empleados federales están cubiertos por leyes similares. Si tiene alguna pregunta sobre su cobertura, pregunte a su empleador.

**¿Cuáles son los beneficios?**
- Cuidado médico: visitas a los doctores, servicios en el hospital, terapia física, análisis, rayos-x y medicinas que sean razonablemente necesarios para tratar su lesión. Nunca debería ver una cuenta. Hay un límite en algunos de los servicios médicos.
- Beneficios por incapacidad temporal (IT): Los pagos si tiene una pérdida salarial mientras se recupera. Para la mayoría de las lesiones, es posible que, los beneficios de IT no se paguen por más de 104 semanas en un plazo de cinco años desde la fecha del accidente. Los beneficios por incapacidad del Estado (Departamento de Desarrollo de Empleo) pueden pagarse si los beneficios de IT se atrasan, se deniegan o se terminan.
- Beneficios por incapacidad permanente (IP): Los pagos si su lesión causa una incapacidad permanente.
- Beneficio suplementario por desplazamiento de empleo: Para las fechas del accidente entre el 1/1/04 y el 31/12/12, se abona un cupón no transferible, pagadero a una escuela aprobada por el estado si su lesión resultara en una incapacidad permanente que le impidiera regresar al trabajo en un plazo de 60 días después de que acabe la IT y su empleador no le ofrece un trabajo modificado o alternativo.
- Para las fechas del accidente el o después del 1/1/13, se abona un cupón no transferible para los costos y gastos relacionados con una formación educativa, si su lesión resulta en una incapacidad permanente y su empleador no le ofrece un trabajo regular, modificado o alternativo en un plazo de 60 días desde su fecha permanente y estacionaria.

- Beneficios por defunción (BD): Se abonan a los dependientes de un trabajador que muere por un accidente o enfermedad profesional laboral. Se abona también un subsidio para el funeral. La cantidad del subsidio para el funeral dependerá de la fecha del accidente.
- Frecuencia de los beneficios de IT, IP y BD: Estos beneficios se pagan cada dos semanas, 2/3 partes del promedio del salario semanal con unos límites máximos y mínimos ya establecidos por la ley.
- Beneficio por regresar a trabajar: Si su lesión resulta en una incapacidad permanente y el estado determina que su IP es muy bajo en comparación con la pérdida de su capacidad para ganar dinero en el futuro, podría calificar para más dinero proveniente del Fondo de Regreso al trabajo del Departamento de Relaciones Industriales. Si tuviera alguna pregunta o piense que califica, póngase en contacto con la información y ayuda que se encuentra listada a continuación o visite el sitio web de DIR en www.dir.ca.gov.

**Seleccionar a su médico antes de una lesión o enfermedad profesional (Preselección):**
Es posible que pueda escoger a un doctor que lo vaya a tratar por una lesión laboral o enfermedad profesional. Si califica, le debe notificar a su empleador, por escrito, el nombre y la dirección de su médico personal o grupo médico antes de que se accidente y su médico debe estar de acuerdo en darle tratamiento causado por el accidente laboral. Para las instrucciones, vea la información por escrito sobre la compensación de los trabajadores por accidentes laborales que su empleador está obligado a dar a cualquier nuevo empleado.

**Si se accidenta:**
1. **Obtenga cuidado médico.** Si necesita cuidado médico, llame al 911 para la ayuda inmediata del hospital, ambulancia, bomberos o departamento de policía y que su empleador se ponga en contacto con Zenith en el 800-440-5020. Si necesita primeros auxilios, póngase en contacto con su empleador.
2. **Haga un informe de su accidente:** Haga un informe inmediatamente de su accidente a su supervisor o a un representante de su empleador. No se retrase. Existen unos límites. Si espera mucho tiempo, podría perder su derecho a los beneficios. Se requiere que su empleador le proporcione un formulario para la reclamación dentro del plazo de un día desde que tenga conocimiento del accidente. En un plazo de un día, debe presentar el formulario de la reclamación, su empleador debe autorizar las provisiones de todo el tratamiento, consistente con las directrices aplicables para tratamiento, para el supuesto accidente y debe ser responsable hasta un máximo de diez mil dólares ($10.000) en tratamiento hasta que la reclamación sea aceptada o rechazada.
3. **Visite a su médico principal para su tratamiento (PTP, en inglés).** Este es el doctor con toda la responsabilidad para darle el tratamiento a su lesión o enfermedad profesional. Si usted ya ha seleccionado a su médico principal o grupo médico al dar el nombre y su dirección (véase Seleccionar a su médico antes de una lesión o enfermedad profesional), puede ir a verlo para el tratamiento bajo ciertas circunstancias. Si no, su empleador tiene el derecho a seleccionar al médico que le va a ofrecer el tratamiento durante los primeros 30 días. Usted podrá cambiar al doctor de su selección después de 30 días. Se aplican reglas diferentes si su empleador ofrece una Organización de cuidado médico (Health Care Organization, HCO), o tiene una Red de proveedores médicos (Medical Provider Network, MPN). Su empleador actual usa la Red de proveedores médicos de Zenith (Zenith Medical Provider Network). Póngase en contacto con Zenith llamando al número a continuación o con su empleador para más información.
4. **Seleccione un proveedor de la Red de Proveedores médicos de Zenith.** Su actual empleador participa en la Red de proveedores médicos de Zenith (ZMPN), la cual es una red selecta de proveedores de cuidados médicos para proporcionar tratamiento a los trabajadores que se accidentan en el trabajo. Usted puede solicitar una copia del aviso de ZMPN llamando a Zenith al número a continuación o en el sitio web que se proporciona a continuación. Si tiene un médico personal o grupo medico preseleccionado por escrito antes de su accidente laboral, es posible que reciba tratamiento del médico o grupo médico preseleccionado. Si no lo ha preseleccionado, puede seleccionar un proveedor del listado de ZMPN después de la primera visita médica indicada por su empleador. Si está recibiendo tratamiento con un doctor que no está en la ZMPN para una lesión ya existente, es posible que se le requiera que cambie a un doctor dentro de la ZMPN. Puede obtener el directorio de la ZMPN llamando a Zenith, al número gratuito 800-440-5020, en línea en www.TheZenith.com o a través de su empleador. No se requiere una contraseña para acceder al directorio. Haga clic en la tecla de "LOCATE" en la parte inferior de la página web para acceder al directorio. Una vez esté en el directorio, puede buscar la dirección, nombre o región del proveedor. Si tiene alguna pregunta sobre la ZMPN o cómo acceder para el cuidado de un accidente laboral, póngase en contacto con el inspector de reclamos de Zenith o con el asistente para el acceso médico de la ZMPN. Se puede poner en contacto con un asistente para el acceso médico llamando al

número gratuito que se encuentra a continuación y al seleccionar el asistente para el acceso médico del menú:

**Número gratuito:** 800-440-5020

**Horas:** De lunes a sábados de las 7h a las 20h Horario del Pacífico

Los proveedores incluidos en la ZMPN se encuentran o bien por el nombre del individuo o por el del grupo/clínica. Si el proveedor o grupo no se encuentra listado por el nombre, no está incluido en la ZMPN. Además, los proveedores, grupos médicos y clínicas están listados por localidades. Solo esas localidades listadas en el directorio de la ZMPN se encuentran en la ZMPN. Los servicios proporcionados por un proveedor que no esté en el listado o la localidad de un consultorio que no esté listado en el directorio de la ZMPN, se encuentran fuera de la red y están sujetos a que se los denieguen.

5. **Seleccionar una farmacia de la red de farmacias de Zenith.** Zenith proporciona los servicios farmacéuticos a través de la red de farmacias de Zenith (ZPN). Todas las recetas para lesiones aprobadas por accidentes laborables deben obtenerse a través de una farmacia participante en la ZPN. Las cuentas de las recetas obtenidas fuera de la ZPN pudieran ser denegadas.
   Los consultorios de los proveedores no están incluidos en la ZPN y los medicamentos dispensados en el consultorio del doctor no van a ser reembolsados a no ser que el medicamento sea razonablemente necesario para el cuidado médico:
   - antivirales
   - antibióticos; o
   - bombas de infusión intratecal (incluyendo otras recetas)

   Las recetas para los antivirales o antibióticos proporcionadas en una farmacia deben ser dispensadas en farmacias participantes en la ZPN. Si tiene alguna pregunta sobre cómo obtener medicamentos con receta médica, llame al administrador de los beneficios de farmacias de la red ZPN, Cadence Rx, número gratuito 888-813-0023. Para usar la herramienta del localizador de farmacias en línea de la ZPN, visite https://cadencerx.com/find-a-pharmacy/.

**Discriminación.** Es ilegal que un empleador le castigue o que lo despida por tener una lesión por un accidente laboral, por presentar una reclamación o por declarar en un caso de accidente laboral de otra persona. Si se prueba, puede recibir pérdidas salariales, ser admitido de nuevo en su trabajo, aumento en beneficios y los costos y gastos hasta los límites establecidos por el estado.

**¿Preguntas?** Obtenga más información acerca de la compensación de los trabajadores por accidentes laborales al leer la información que se requiere que su empleador le proporcione cuando lo contrató. Si tiene preguntas, diríjase a su empleador o al administrador de las reclamaciones (el que administra las reclamaciones para la compensación de los trabajadores por accidentes laborales de su empleador):

**Administrador de las reclamaciones**: Zenith Insurance Company
**Número de identificación de ZMPN:** 3142
**Número gratuito:** 800-440-5020
**Portador/Autoasegurador:** Zenith Insurance Company o ZNAT Insurance Company
**Fecha de caducidad de la póliza:** December 31, 2023

Si la póliza para la compensación de los trabajadores por accidentes laborales ha caducado, póngase en contacto con el Inspector Laboral en la División de cumplimiento para los estándares laborales (Labor Standards Enforcement, DLSE).

También puede obtener información gratuita sobre la compensación de los trabajadores por accidentes laborales a través de la Información sobre la compensación por accidentes laborales de la División del Estado y del Agente del seguro. La información más cercana y el agente de seguro pueden encontrarse en la lista adjunta en www.dir.ca.gov/dwc/IandA.html o puede llamar al número gratuito 800-736-7401.

Es posible que su empleador no sea responsable por el pago de beneficios de compensación de trabajadores para ninguna lesión que proviene de su participación voluntaria en cualquier actividad fuera del trabajo, recreativa, social, o atletismo que no sea parte de sus deberes laborales.

## EL FRAUDE A LA LEY DE COMPENSACIÓN A LOS TRABAJADORES ES UN DELITO GRAVE

**Cualquier persona que haga o que ocasione que se haga una declaración falsa o fraudulenta con el propósito de obtener o negar el pago o beneficios de compensación a los trabajadores es culpable de un delito grave. La pena impuesta, de ser encontrado culpable de fraude puede ser hasta de $150,000 en multas y hasta cinco años en prisión.**

Usted también puede obtener información gratis sobre la ley de compensación a los trabajadores consultando con un Funcionario de Información y Asistencia de la División de Compensación de Trabajadores del Estado. El Funcionario de Información y Asistencia más cercano a usted lo puede encontrar llamando gratis al (800) 736-7401. Para mayor información sobre el DWC y DLSE en el Internet: www.dwc.ca.gov o www.dir.ca.gov/dlse.

**La siguiente es una lista de los lugares y los números telefónicos de los oficiales de información y asistencia. La lista también la puede obtener en el Internet en: www.dir.ca.gov/DWC/ianda.html**

| | | | |
|---|---|---|---|
| Anaheim<br>1065 N. PacifiCenter Drive<br>Anaheim 92806-2141<br>714-414-1801 | Bakersfield<br>1800 30th Street, Suite 100<br>Bakersfield, CA 93301-1929<br>661-395-2514 | Eureka<br>409 K Street, Room 201<br>Eureka, CA 95501-0481<br>707-441-5723 | Fresno<br>2550 Mariposa Mall, Room 5005<br>Fresno, CA 93721-2219<br>559-445-5355 |
| Long Beach<br>300 Oceangate Street, Suite 200<br>Long Beach, CA 90802-4304<br>562-590-5240 | Los Angeles<br>320 W. 4th Street, 9th floor<br>Los Angeles, CA 90013-1954<br>213-576-7389 | Marina del Rey<br>4720 Lincoln Blvd, 2nd floor<br>Marina del Rey, CA 90292-6902<br>310-482-3820 | Oakland<br>1515 Clay Street, 6th floor<br>Oakland, CA 94612-1519<br>510-622-2861 |
| Oxnard<br>1901 N. Rice Ave., Suite 200<br>Oxnard, CA 93030-7912<br>805-485-3528 | Pomona<br>732 Corporate Center Drive<br>Pomona, CA 91768-2653<br>909-623-8568 | Redding<br>250 Hemsted Drive, 2nd floor, Suite B<br>Redding, CA 96002-9040<br>530-225-2047 | Riverside<br>3737 Main Street, Room 300<br>Riverside, CA 92501-3337<br>951-782-4347 |
| Sacramento<br>160 Promenade Circle, Suite 300<br>Sacramento, CA 95834-2962<br>916-928-3158 | Salinas<br>1880 North Main St., Suite 100<br>Salinas, CA 93906-2037<br>831-443-3058 | San Bernardino<br>464 W. Fourth Street, Suite 239<br>San Bernardino, CA 92401-1411<br>909-383-4522 | San Diego<br>7575 Metropolitan Drive, Suite 202<br>San Diego, CA 92108-4424<br>619-767-2082 |
| San Francisco<br>455 Golden Gate Ave., 2nd floor<br>San Francisco, CA 94102-7014<br>415-703-5020 | San Jose<br>100 Paseo de San Antonio, Rm 241<br>San Jose, CA 95113-1402<br>408-277-1292 | San Luis Obispo<br>4740 Allene Way, Suite 100<br>San Luis Obispo, CA 93401-8736<br>805-596-4159 | Santa Ana<br>2 MacArthur Place, Suite 600<br>Santa Ana, CA 92707-7704<br>714-942-7576 |
| Santa Barbara<br>130 E. Ortega Street<br>Santa Barbara, CA 93101-7538<br>805-568-1295 | Santa Rosa<br>50 "D" Street, Room 420<br>Santa Rosa, CA 95404-4771<br>707-576-2452 | Stockton<br>31 E. Channel Street, Room 344<br>Stockton, CA 95202-2314<br>209-948-7980 | Van Nuys<br>6150 Van Nuys Blvd., Room 105<br>Van Nuys, CA 91401-3370<br>818-901-5367 |

**INFORMACIÓN Y RECURSOS ADICIONALES**

Visite TheZenith.com:

En donde:

- Para ver un video sobre el proceso de recuperación
- Para obtener una lista completa de proveedores de ZMPN en su área
- Para leer más sobre el proceso de reclamo

Si usted necesita hablar con alguien sobre la ZMPN, contacte el Grupo de Proveedores de Zenith llamando al 800-440-5020. Para encontrar una farmacia participante, visite https://cadencerx.com/find-a-pharmacy/.

**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 multi-specialty medical group providing comprehensive medical services predominately 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 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 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**

Please be aware that Zenith utilizes a Medical Provider Network but is required to provide the following notice:

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.

**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)

_____ Date: _____
(Employee signature)

## DESIGNACIÓN PREVIA DE MÉDICO PARTICULAR

En caso de que usted sufra una lesión o enfermedad relacionada con su empleo, usted puede recibir tratamiento médico por esa lesión o enfermedad de su médico particular (M.D.), médico osteópata (D.O.) o grupo médico si:

- usted tiene un plan de salud grupal
- el médico es su médico familiar o de cabecera, que será un médico que ha limitado su práctica médica a medicina general o que es un internista certificado o elegible para certificación, pediatra, gineco-obstreta, o médico de medicina familiar y que previamente ha estado a cargo de
- su tratamiento médico y tiene su expediente médico su "médico particular" puede ser un grupo médico si es una corporación o sociedad o asociación compuesta de doctores certificados en medicina u osteopatía, que opera un integrado grupo médico multidisciplinario que predominantemente proporciona amplios servicios médicos para lesiones y enfermedades no relacionadas con el trabajo.
- antes de la lesión su médico está de acuerdo a proporcionarle tratamiento médico para su lesión o enfermedad de trabajo
- antes de la lesión usted le proporcionó a su empleador por escrito lo siguiente: (1) notificación de que quiere que su médico particular le brinde tratamiento para una lesión o enfermedad de trabajo y (2) el nombre y dirección comercial de su médico particular.

Puede utilizar este formulario para notificarle a su empleador que desea que su médico particular o médico osteópata lo atienda para una lesión o enfermedad de trabajo y que los requisitos mencionados arriba han sido cumplidos.

## NOTICIA DE DESIGNACIÓN PREVIA DE MÉDICO PARTICULAR

**Empleado: Llene esta sección.**

A: _____ (nombre del empleador) Si tengo una lesión o enfermedad de trabajo, yo elijo ser atendido por:

Nombre del médico: (M.D., D.O., o grupo médico): _____

_____

Dirección (ciudad, estado, código postal): _____

_____

Número de teléfono: _____

Nombre del Empleado (en letras de molde, por favor): _____

_____

Domicilio del Empleado: _____

_____

Firma del Empleado_____ Fecha:_____

Médico: Estoy de acuerdo con esta Designación Previa:

Firma: _____ Fecha:_____
(Médico o Empleado designado por el Médico o Grupo Médico)

El médico no está obligado a firmar este formulario, sin embargo, si el médico o empleado designado por el médico o grupo médico no firma, será necesario presentar documentación sobre el consentimiento del médico de ser designado previamente de acuerdo al Código de Reglamentos de California, Título 8, sección 9780.1(a) (3).

## AVISO DE QUIROPRÁCTICO PERSONAL O ACUPUNTURISTA PERSONAL

Tenga en cuenta que Zenith utiliza una Red de Proveedores Médicos, pero está obligado a proporcionar el siguiente aviso:

Si su empleador o la compañía de seguros de su empleador no tiene una Red de Proveedores Médicos establecida, posiblemente puede cambiar su médico que lo está atendiendo a su quiropráctico o acupunturista personal después de una lesión o enfermedad de trabajo. Para hacer este cambio, usted debe darle por escrito a su empleador el nombre y la dirección comercial de un quiropráctico o acupunturista personal antes de la lesión o enfermedad. Generalmente, su administrador de reclamos tiene el derecho de elegir al médico que le proporcionará el tratamiento dentro de los primeros 30 días después de que su empleador sepa de su lesión o enfermedad. Después de que su administrador de reclamos ha iniciado su tratamiento con otro médico durante este tiempo, puede entonces usted, bajo petición, transferir su tratamiento a su quiropráctico o acupunturista personal.

Puede utilizar este formulario para notificarle a su empleador de su quiropráctico o acupunturista personal.

La ley estatal no permite que un quiropráctico siga como su médico después de 24 visitas.

**Información sobre su Quiropráctico o Acupunturista**

_____
(Nombre del quiropráctico o acupunturista)

_____
(Dirección, ciudad, estado, código postal)

_____
(Número de teléfono)

_____
(Nombre del Empleado – en letras de molde, por favor)

_____
(Domicilio del Empleado)

_____ Fecha: _____
(Firma del Empleado)

# THOMAS JEFFERSON SCHOOL OF LAW
## 2023 PAYROLL SCHEDULE

**TIMESHEETS ARE DUE BY CLOSE OF BUSINESS ON THE LAST DAY OF EACH PAY PERIOD UNLESS OTHERWISE NOTED**

**Timesheets must be Accurate, Complete & Approved by both the Employee and Supervisor by the due date.**

**PAY PERIOD DATES:**

| PP # | BEGIN | END | TIMESHEETS DUE | PAY DATE |
|---|---|---|---|---|
| 1 | 12/24/23 | 01/06/23 | 01/06/23 | 01/13/23 |
| 2 | 01/07/23 | 01/20/23 | 01/20/23 | 01/27/23 |
| 3 | 01/21/23 | 02/03/23 | 02/03/23 | 02/10/23 |
| 4 | 02/04/23 | 02/17/23 | 02/17/23 | 02/24/23 |
| 5 | 02/18/23 | 03/03/23 | 03/03/23 | 03/10/23 |
| 6 | 03/04/23 | 03/17/23 | 03/17/23 | 03/24/23 |
| 7 | 03/18/23 | 03/31/23 | 03/31/23 | 04/07/23 |
| 8 | 04/01/23 | 04/14/23 | 04/14/23 | 04/21/23 |
| 9 | 04/15/23 | 04/28/23 | 04/28/23 | 05/05/23 |
| 10 | 04/29/23 | 05/12/23 | 05/12/23 | 05/19/23 |
| 11 | 05/13/23 | 05/26/23 | 05/26/23 | 06/02/23 |
| 12 | 05/27/23 | 06/09/23 | 06/09/23 | 06/16/23 |
| 13 | 06/10/23 | 06/23/23 | 06/23/23 | 06/30/23 |
| 14 | 06/24/23 | 07/07/23 | 07/07/23 | 07/14/23 |
| 15 | 07/08/23 | 07/21/23 | 07/21/23 | 07/28/23 |
| 16 | 07/22/23 | 08/04/23 | 08/04/23 | 08/11/23 |
| 17 | 08/05/23 | 08/18/23 | 08/18/23 | 08/25/23 |
| 18 | 08/19/23 | 09/01/23 | 09/01/23 | 09/08/23 |
| 19 | 09/02/23 | 09/15/23 | 09/15/23 | 09/22/23 |
| 20 | 09/16/23 | 09/29/23 | 09/29/23 | 10/06/23 |
| 21 | 09/30/23 | 10/13/23 | 10/13/23 | 10/20/23 |
| 22 | 10/14/23 | 10/27/23 | 10/27/23 | 11/03/23 |
| 23 | 10/28/23 | 11/10/23 | 11/10/23 | 11/17/23 |
| 24 | 11/11/23 | 11/24/23 | *11/22/23 | 12/01/23 |
| 25 | 11/25/23 | 12/08/23 | 12/08/23 | 12/15/23 |
| 26 | 12/09/23 | 12/22/23 | *12/19/23 | 12/29/23 |

***Indicates timesheets due on an earlier date***

THOMAS JEFFERSON SCHOOL OF LAW
SAN DIEGO • CALIFORNIA

# FEDERAL WORK-STUDY (FWS) TIMESHEET

*(TIMESHEETS MUST BE SUBMITTED BY 10 A.M. ACCORDING TO THE PAYROLL SCHEDULE PROVIDED BY THE FINANCIAL AID OFFICE)*

**STUDENT NAME:** _____ **STUDENT ID #:** _____

**POSITION TITLE & DEPARTMENT/AGENCY:** _____ **AGENCY ADDRESS (CITY, STATE, ZIP):** _____

**PAY PERIOD BEGINNING:** ____/____/____ **AND ENDING:** ____/____/____

| DAY | *DATE* | TIME IN | TIME OUT | TIME IN | TIME OUT | HOURS WORKED | SICK TIME *(if available)* | ACTIVITY | SUPERVISOR'S INITIALS |
|---|---|---|---|---|---|---|---|---|---|
| SATURDAY (WEEK 1) | / | | | | | | | | |
| SUNDAY (WEEK 1) | / | | | | | | | | |
| MONDAY (WEEK 1) | / | | | | | | | | |
| TUESDAY (WEEK 1) | / | | | | | | | | |
| WEDNESDAY (WEEK 1) | / | | | | | | | | |
| THURSDAY (WEEK 1) | / | | | | | | | | |
| FRIDAY (WEEK 1) | / | | | | | | | | |
| SATURDAY (WEEK 2) | / | | | | | | | | |
| SUNDAY (WEEK 2) | / | | | | | | | | |
| MONDAY (WEEK 2) | / | | | | | | | | |
| TUESDAY (WEEK 2) | / | | | | | | | | |
| WEDNESDAY (WEEK 2) | / | | | | | | | | |
| THURSDAY (WEEK 2) | / | | | | | | | | |
| FRIDAY (WEEK 2) | / | | | | | | | | |

| | |
|---|---|
| | *TOTAL HOURS WORKED* |
| | *TOTAL HOURS SICK* |
| | *TOTAL HOURS* |
| $ | *HOURLY PAY RATE* |
| $ | *GROSS EARNINGS* |

*"I hereby certify that the hours worked are true and correct, and the work performed was in accordance with the FWS Student Packet. I also certify that I did not earn academic credit for hours submitted under FWS".*

**Student's Signature:** _____ **Date:** _____

**Supervisor's Signature:** _____ **Date:** _____

FINANCIAL AID OFFICE USE ONLY

**TOTAL:** _____ **APPROVAL:** _____ **DATE:** _____