

NEW HIRE CHECKLIST

The following items must be signed and contained in every new hire employee packet. If a document does not apply, please write N/A. Please initial that the document has been presented to the employee and signed.

Employment Application (completed, dated and signed by applicant)	(Optional)	_____
Labor Code Section 2810.5 for New Hires	(Mandatory)	_____
Post-Hire Employee Data Sheet	(Optional)	_____
Federal Form W-4 - Employee Withholding Allowance	(Mandatory)	_____
California State Form DE-4 Employees Withholding Allowance Certificate	(Mandatory)	_____
I-9 Form - (completed by applicant and company representative)	(Mandatory)	_____
I-9 Instructions	(Mandatory)	_____
Voluntary Information Form	(Optional)	_____
Authorization to obtain Investigative Report	(Optional)	_____
Notification of Request for Investigative Consumer Report	(Optional)	_____
Summary of Rights Under the Fair Credit Reporting Act	(Optional)	_____
Workers' Compensation Benefits Statement and Physician Election Form (English and Spanish/Acknowledgment)	(Mandatory)	_____
State Disability Insurance Booklet-DE-2515 (English/Spanish)	(Mandatory)	_____
EDD For Your Benefit Booklet-DE-2320 (English)	(Mandatory)	_____
Family Care and Medical Leave and Pregnancy Disability Leave (DFEH-100-21) (State) (Replaces Notice B)	(Optional)	_____
Family and Medical Leave Act of 1993 (Federal)	(Optional)	_____
California Paid Family Leave-DE-2511 (English and Spanish)	(Mandatory)	_____
Department of Fair Employment and Housing Sexual Harassment Pamphlet (English and Spanish)	(Mandatory)	_____
Lactation Accommodation Policy	(Mandatory)	_____
Rights of Victims of Domestic Violence, Sexual Assault and Stalking	(Mandatory)	_____
Employee Relations Policy with Acknowledgment (English & Spanish)	(Mandatory)	_____
Company's Drug and Alcohol Policy with Acknowledgment	(Optional)	_____
Meal and Rest Period Policy	(Optional)	_____
Sick Leave Policy	(Mandatory)	_____
Timesheet	(Optional)	_____
Employee Handbook (Company handbook)	(Optional)	_____
Employee Statement Re: Acknowledgment of Receipt of Handbook	(Optional)	_____
Insurance Premium Authorization	(Optional)	_____
Unearned Vacation Agreement	(Optional)	_____
Supplies/Uniform Cost Authorization	(Optional)	_____
Acknowledgment of Receipt of Mandatory Documents	(Optional)	_____

Date: _____

By: _____

Supervisor's Signature

Date: _____

By: _____

EMPLOYMENT APPLICATION

GENERAL DATA

Last Name	First Name	Middle Name				
Have you ever used another name? <input type="checkbox"/> Yes <input type="checkbox"/> No						
If yes, please specify for purposes of a reference check: _____ _____						
Present Address	Number	Street	City	State	Zip Code	
Years at Above Address			Home Telephone Number ()			
Position Applying For					Date of Application	
Full Time or Part Time			Shift or Hours Preferred			
Drivers License Number (if applicable)			Expiration Date			

If employed in the position for which you have applied, would you be in a supervisory or subordinate relationship to any relative of your household? Yes No

PERSONAL DATA

Person to notify in case of an Emergency:	Name	Home Telephone Number ()				
Present Address	Number	Street	City	State	Zip Code	
<i>How did you learn of this job opening?</i>						
<input type="checkbox"/> Advertisement	<input type="checkbox"/> Friend	<input type="checkbox"/> Walk-In				
<input type="checkbox"/> Employment Agency	<input type="checkbox"/> Relative	<input type="checkbox"/> Other _____				
List membership in professional organizations which you feel would enhance your application. You may exclude any whose names would indicate the race, religious creed, color, national origin, or ancestry of its members. _____ _____						

WE ARE AN EQUAL OPPORTUNITY EMPLOYER

If under 18 years of age, can you after employment, submit a work permit? N/A Yes No

SKILLS

Typing Speed (wpm):	Shorthand (wpm):
Machines Operated:	
Other Training/Skills (include bilingual ability if relevant to the position for which you are applying:	
Branch of Military Service:	State Dates: From: To:
State relative skills acquired during military service:	

PROFESSIONAL & TECHNICAL APPLICANTS ONLY

Professional License Number:	Expiration Date:	Type of License:	State:
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Is there any reason why you would be unable to perform or to safely perform any of the duties of the position for which you have applied, as set forth on the job description for that position? Yes No

If "Yes," please explain:

EDUCATION

	HIGH SCHOOL	COLLEGE	TRADE, PROFESSIONAL SCHOOL OR OTHER
Name			
Address			
Number of Years			
Course or Major			
Diploma/Degree			

WORK EXPERIENCE

Last/Present Employer	Length of Service (Dates)		Duties Performed
Address	<u>Start</u>	<u>Leave</u>	
Telephone Number(s)			
Supervisor's Name and Position			
Your Job Title			
Reason For Leaving			
May we contact now? <input type="checkbox"/> Yes <input type="checkbox"/> No (If still employed)			
Employer	Length of Service (Dates)		Duties Performed
Address	<u>Start</u>	<u>Leave</u>	
Telephone Number(s)			
Supervisor's Name and Position			
Your Job Title			
Reason For Leaving			
May we contact now? <input type="checkbox"/> Yes <input type="checkbox"/> No (If still employed)			
Employer	Length of Service (Dates)		Duties Performed
Address	<u>Start</u>	<u>Leave</u>	
Telephone Number(s)			
Supervisor's Name and Position			
Your Job Title			
Reason For Leaving			
May we contact now? <input type="checkbox"/> Yes <input type="checkbox"/> No (If still employed)			

APPLICANT'S STATEMENT

I hereby certify that I have been informed of the duties, the hours and days of work of the position for which I am applying, and that the information on this application is correct and complete to the best of my knowledge.

I agree to have any of the statements checked by the Company unless I have indicated to the contrary. Further, I understand that falsification or omission of any material information on this application, if I receive a job offer, may be considered sufficient cause for immediate termination. I agree that if employed, I will abide by all policies and procedures established by the employer.

I hereby acknowledge that my employment is "at-will," that I may resign at any time and the Company may terminate my employment at any time, with or without cause, and with or without notice, that any assurances of continued employment, whether written, oral or by conduct, shall not be interpreted as changing the nature of the employment relationship unless specifically acknowledged in writing by the President of the Company.

By: _____
Signature of Applicant

Date

FOR COMPANY USE ONLY

Interviewed: Yes No

Remarks: _____

Employed: Yes No Starting Date: _____

Job Title: _____ Salary: _____ Dept: _____

By: _____
Name and Title Date

(Revised 11-06-2017)

NOTICE TO EMPLOYEE
Labor Code section 2810.5

EMPLOYEE

Employee Name: _____
Start Date: _____

EMPLOYER

Legal Name of Hiring Employer: _____

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

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

Physical Address of Hiring Employer's Main Office:

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

Hiring Employer's Telephone Number: _____

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

Name: _____

Physical Address of Main Office: _____

Mailing Address: _____

Telephone Number: _____

WAGE INFORMATION

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

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

Other (provide specifics): _____

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

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

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

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

Regular Payday: _____

WORKER'S COMPENSATION

Insurance Carrier's Name: _____

Address: _____

Telephone Number: _____

Policy No.: _____

Self-Insured (Labor Code 3700) and Certificate Number for Consent to Self-Insure: _____

PAID SICK LEAVE

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

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

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

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

ACKNOWLEDGEMENT OF RECEIPT

(Optional)

(PRINT NAME of Employer representative)

(PRINT NAME of Employee)

(SIGNATURE of Employer Representative)

(SIGNATURE of Employee)

(Date)

(Date)

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

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

POST-HIRE EMPLOYEE DATA SHEET

Personal Information:

Name: _____

Address: _____

Phone No.: _____ Date of Birth: _____

Social Security No.: _____

Name of Whom to Contact in Emergency: (Name) _____

(Phone) _____

The following information may be obtained if there is a business need for such information, e.g., health benefits:

Marital Status: _____

Spouse's Name: _____ Date of Birth: _____

List of Dependents:

Name	Relationship	SSN	Date of Birth
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Date of Hire: _____ Rate of Pay: _____

Benefits Arrangements:

Vacation: _____ Sick Days _____

Insurance: _____

Review Date: _____

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.**

2020

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) <input type="checkbox"/> Single or Married filing separately <input type="checkbox"/> Married filing jointly (or Qualifying widow(er)) <input type="checkbox"/> 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, when to use the online estimator, 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) Use the estimator at www.irs.gov/W4App for most accurate withholding for this step (and Steps 3–4); **or**

(b) Use the Multiple Jobs Worksheet on page 3 and enter the result in Step 4(c) below for roughly accurate withholding; **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 accurate for jobs with similar pay; otherwise, more tax than necessary may be withheld ▶

TIP: To be accurate, submit a 2020 Form W-4 for all other jobs. If you (or your spouse) have self-employment income, including as an independent contractor, use the estimator.

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 Dependents	If your 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 and 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)
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General Instructions

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.

Exemption from withholding. You may claim exemption from withholding for 2020 if you meet both of the following conditions: you had no federal income tax liability in 2019 **and** you expect to have no federal income tax liability in 2020. You had no federal income tax liability in 2019 if (1) your total tax on line 16 on your 2019 Form 1040 or 1040-SR is zero (or less than the sum of lines 18a, 18b, and 18c), 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 2020 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 16, 2021.

Your privacy. If you prefer to limit information provided in Steps 2 through 4, use the online estimator, which will also increase accuracy.

As an alternative to the estimator: 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). If this is the only job in your household, you may instead check the box in Step 2(c), which will increase your withholding and significantly reduce your paycheck (often by thousands of dollars over the year).

When to use the estimator. Consider using the estimator at www.irs.gov/W4App if you:

1. Expect to work only part of the year;
2. Have dividend or capital gain income, or are subject to additional taxes, such as the additional Medicare tax;
3. Have self-employment income (see below); or
4. Prefer the most accurate withholding for multiple job situations.

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 these taxes through withholding from your wages, use the estimator at www.irs.gov/W4App to figure the amount to have withheld.

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.

Option **(a)** most accurately calculates the additional tax you need to have withheld, while option **(b)** does so with a little less accuracy.

If you (and your spouse) have a total of only two jobs, you may instead 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. Step 3 of Form W-4 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. 972, Child Tax Credit and Credit for Other Dependents. You can also include **other tax credits** in this step, such as education tax credits and the foreign tax credit. 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 2020 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.

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; or, you can use the online withholding estimator at www.irs.gov/W4App.

- 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
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
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
c Add the amounts from lines 2a and 2b and enter the result on line 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.
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)

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



- 1 Enter an estimate of your 2020 itemized deductions (from Schedule A (Form 1040 or 1040-SR)). 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
2 Enter: { \$24,800 if you're married filing jointly or qualifying widow(er); \$18,650 if you're head of household; \$12,400 if you're single or married filing separately }
3 If line 1 is greater than line 2, subtract line 2 from line 1. If line 2 is greater than line 1, enter "-0-"
4 Enter an estimate of your student loan interest, deductible IRA contributions, and certain other adjustments (from Part II of Schedule 1 (Form 1040 or 1040-SR)). See Pub. 505 for more information
5 Add lines 3 and 4. Enter the result here and in Step 4(b) of Form W-4

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 possessions for use in administering their tax laws; and to the Department of Health and Human Services for use in the National Directory of New Hires. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

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

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

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

Married Filing Jointly or Qualifying Widow(er)

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	\$220	\$850	\$900	\$1,020	\$1,020	\$1,020	\$1,020	\$1,020	\$1,210	\$1,870	\$1,870
\$10,000 - 19,999	220	1,220	1,900	2,100	2,220	2,220	2,220	2,220	2,410	3,410	4,070	4,070
\$20,000 - 29,999	850	1,900	2,730	2,930	3,050	3,050	3,050	3,240	4,240	5,240	5,900	5,900
\$30,000 - 39,999	900	2,100	2,930	3,130	3,250	3,250	3,440	4,440	5,440	6,440	7,100	7,100
\$40,000 - 49,999	1,020	2,220	3,050	3,250	3,370	3,570	4,570	5,570	6,570	7,570	8,220	8,220
\$50,000 - 59,999	1,020	2,220	3,050	3,250	3,570	4,570	5,570	6,570	7,570	8,570	9,220	9,220
\$60,000 - 69,999	1,020	2,220	3,050	3,440	4,570	5,570	6,570	7,570	8,570	9,570	10,220	10,220
\$70,000 - 79,999	1,020	2,220	3,240	4,440	5,570	6,570	7,570	8,570	9,570	10,570	11,220	11,240
\$80,000 - 99,999	1,060	3,260	5,090	6,290	7,420	8,420	9,420	10,420	11,420	12,420	13,260	13,460
\$100,000 - 149,999	1,870	4,070	5,900	7,100	8,220	9,320	10,520	11,720	12,920	14,120	14,980	15,180
\$150,000 - 239,999	2,040	4,440	6,470	7,870	9,190	10,390	11,590	12,790	13,990	15,190	16,050	16,250
\$240,000 - 259,999	2,040	4,440	6,470	7,870	9,190	10,390	11,590	12,790	13,990	15,520	17,170	18,170
\$260,000 - 279,999	2,040	4,440	6,470	7,870	9,190	10,390	11,590	13,120	15,120	17,120	18,770	19,770
\$280,000 - 299,999	2,040	4,440	6,470	7,870	9,190	10,720	12,720	14,720	16,720	18,720	20,370	21,370
\$300,000 - 319,999	2,040	4,440	6,470	8,200	10,320	12,320	14,320	16,320	18,320	20,320	21,970	22,970
\$320,000 - 364,999	2,720	5,920	8,750	10,950	13,070	15,070	17,070	19,070	21,290	23,590	25,540	26,840
\$365,000 - 524,999	2,970	6,470	9,600	12,100	14,530	16,830	19,130	21,430	23,730	26,030	27,980	29,280
\$525,000 and over	3,140	6,840	10,170	12,870	15,500	18,000	20,500	23,000	25,500	28,000	30,150	31,650

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	\$460	\$940	\$1,020	\$1,020	\$1,470	\$1,870	\$1,870	\$1,870	\$1,870	\$2,040	\$2,040	\$2,040
\$10,000 - 19,999	940	1,530	1,610	2,060	3,060	3,460	3,460	3,460	3,640	3,830	3,830	3,830
\$20,000 - 29,999	1,020	1,610	2,130	3,130	4,130	4,540	4,540	4,720	4,920	5,110	5,110	5,110
\$30,000 - 39,999	1,020	2,060	3,130	4,130	5,130	5,540	5,720	5,920	6,120	6,310	6,310	6,310
\$40,000 - 59,999	1,870	3,460	4,540	5,540	6,690	7,290	7,490	7,690	7,890	8,080	8,080	8,080
\$60,000 - 79,999	1,870	3,460	4,690	5,890	7,090	7,690	7,890	8,090	8,290	8,480	9,260	10,060
\$80,000 - 99,999	2,020	3,810	5,090	6,290	7,490	8,090	8,290	8,490	9,470	10,460	11,260	12,060
\$100,000 - 124,999	2,040	3,830	5,110	6,310	7,510	8,430	9,430	10,430	11,430	12,420	13,520	14,620
\$125,000 - 149,999	2,040	3,830	5,110	7,030	9,030	10,430	11,430	12,580	13,880	15,170	16,270	17,370
\$150,000 - 174,999	2,360	4,950	7,030	9,030	11,030	12,730	14,030	15,330	16,630	17,920	19,020	20,120
\$175,000 - 199,999	2,720	5,310	7,540	9,840	12,140	13,840	15,140	16,440	17,740	19,030	20,130	21,230
\$200,000 - 249,999	2,970	5,860	8,240	10,540	12,840	14,540	15,840	17,140	18,440	19,730	20,830	21,930
\$250,000 - 399,999	2,970	5,860	8,240	10,540	12,840	14,540	15,840	17,140	18,440	19,730	20,830	21,930
\$400,000 - 449,999	2,970	5,860	8,240	10,540	12,840	14,540	15,840	17,140	18,450	19,940	21,240	22,540
\$450,000 and over	3,140	6,230	8,810	11,310	13,810	15,710	17,210	18,710	20,210	21,700	23,000	24,300

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	\$830	\$930	\$1,020	\$1,020	\$1,020	\$1,480	\$1,870	\$1,870	\$1,930	\$2,040	\$2,040
\$10,000 - 19,999	830	1,920	2,130	2,220	2,220	2,680	3,680	4,070	4,130	4,330	4,440	4,440
\$20,000 - 29,999	930	2,130	2,350	2,430	2,900	3,900	4,900	5,340	5,540	5,740	5,850	5,850
\$30,000 - 39,999	1,020	2,220	2,430	2,980	3,980	4,980	6,040	6,630	6,830	7,030	7,140	7,140
\$40,000 - 59,999	1,020	2,530	3,750	4,830	5,860	7,060	8,260	8,850	9,050	9,250	9,360	9,360
\$60,000 - 79,999	1,870	4,070	5,310	6,600	7,800	9,000	10,200	10,780	10,980	11,180	11,580	12,380
\$80,000 - 99,999	1,900	4,300	5,710	7,000	8,200	9,400	10,600	11,180	11,670	12,670	13,580	14,380
\$100,000 - 124,999	2,040	4,440	5,850	7,140	8,340	9,540	11,360	12,750	13,750	14,750	15,770	16,870
\$125,000 - 149,999	2,040	4,440	5,850	7,360	9,360	11,360	13,360	14,750	16,010	17,310	18,520	19,620
\$150,000 - 174,999	2,040	5,060	7,280	9,360	11,360	13,480	15,780	17,460	18,760	20,060	21,270	22,370
\$175,000 - 199,999	2,720	5,920	8,130	10,480	12,780	15,080	17,380	19,070	20,370	21,670	22,880	23,980
\$200,000 - 249,999	2,970	6,470	8,990	11,370	13,670	15,970	18,270	19,960	21,260	22,560	23,770	24,870
\$250,000 - 349,999	2,970	6,470	8,990	11,370	13,670	15,970	18,270	19,960	21,260	22,560	23,770	24,870
\$350,000 - 449,999	2,970	6,470	8,990	11,370	13,670	15,970	18,270	19,960	21,260	22,560	23,900	25,200
\$450,000 and over	3,140	6,840	9,560	12,140	14,640	17,140	19,640	21,530	23,030	24,530	25,940	27,240



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

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

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

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

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

Last Name <i>(Family Name)</i>		First Name <i>(Given Name)</i>		Middle Initial	Other Last Names Used <i>(if any)</i>	
Address <i>(Street Number and Name)</i>			Apt. Number	City or Town		State ZIP Code
Date of Birth <i>(mm/dd/yyyy)</i>	U.S. Social Security Number □□□□ - □□ - □□□□		Employee's E-mail Address			Employee's Telephone Number

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

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

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

Signature of Employee	Today's Date <i>(mm/dd/yyyy)</i>
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Preparer and/or Translator Certification (check one):
 I did not use a preparer or translator. A preparer(s) and/or translator(s) assisted the employee in completing Section 1.
(Fields below must be completed and signed when preparers and/or translators assist an employee in completing Section 1.)

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

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

STOP Employer Completes Next Page **STOP**



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

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

Section 2. Employer or Authorized Representative Review and Verification

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

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

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

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

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

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

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

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

Document Title	Document Number	Expiration Date (if any) (mm/dd/yyyy)
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I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented document(s), the document(s) I have examined appear to be genuine and to relate to the individual.

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

All documents must be UNEXPIRED

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

LIST A Documents that Establish Both Identity and Employment Authorization	OR	LIST B Documents that Establish Identity	AND	LIST C Documents that Establish Employment Authorization
<ol style="list-style-type: none"> 1. U.S. Passport or U.S. Passport Card 2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551) 3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa 4. Employment Authorization Document that contains a photograph (Form I-766) 5. For a nonimmigrant alien authorized to work for a specific employer because of his or her status: <ol style="list-style-type: none"> a. Foreign passport; and b. Form I-94 or Form I-94A that has the following: <ol style="list-style-type: none"> (1) The same name as the passport; and (2) An endorsement of the alien's nonimmigrant status as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form. 6. Passport from the Federated States of Micronesia (FSM) or the Republic of the Marshall Islands (RMI) with Form I-94 or Form I-94A indicating nonimmigrant admission under the Compact of Free Association Between the United States and the FSM or RMI 	OR	<ol style="list-style-type: none"> 1. Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address 2. ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address 3. School ID card with a photograph 4. Voter's registration card 5. U.S. Military card or draft record 6. Military dependent's ID card 7. U.S. Coast Guard Merchant Mariner Card 8. Native American tribal document 9. Driver's license issued by a Canadian government authority <li style="text-align: center;">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 	AND	<ol style="list-style-type: none"> 1. A Social Security Account Number card, unless the card includes one of the following restrictions: <ol style="list-style-type: none"> (1) NOT VALID FOR EMPLOYMENT (2) VALID FOR WORK ONLY WITH INS AUTHORIZATION (3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION 2. Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240) 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. Native American tribal document 5. U.S. Citizen ID Card (Form I-197) 6. Identification Card for Use of Resident Citizen in the United States (Form I-179) 7. Employment authorization document issued by the Department of Homeland Security

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

Refer to the instructions for more information about acceptable receipts.



Instructions for Form I-9, Employment Eligibility Verification

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

USCIS
Form I-9

OMB No. 1615-0047
Expires 10/31/2022

Anti-Discrimination Notice. It is illegal to discriminate against work-authorized individuals in hiring, firing, recruitment or referral for a fee, or in the employment eligibility verification (Form I-9 and E-Verify) process based on that individual's citizenship status, immigration status or national origin. Employers CANNOT specify which document(s) the employee may present to establish employment authorization. The employer must allow the employee to choose the documents to be presented from the Lists of Acceptable Documents, found on the last page of Form I-9. The refusal to hire or continue to employ an individual because the documentation presented has a future expiration date may also constitute illegal discrimination. For more information, contact the Immigrant and Employee Rights Section (IER) in the Department of Justice's Civil Rights Division at <https://www.justice.gov/ier>.

What is the Purpose of This Form?

Employers must complete Form I-9 to document verification of the identity and employment authorization of each new employee (both citizen and noncitizen) hired after November 6, 1986, to work in the United States. In the Commonwealth of the Northern Mariana Islands (CNMI), employers must complete Form I-9 to document verification of the identity and employment authorization of each new employee (both citizen and noncitizen) hired after November 27, 2011.

General Instructions

Both employers and employees are responsible for completing their respective sections of Form I-9. For the purpose of completing this form, the term “employer” means all employers, including those recruiters and referrers for a fee who are agricultural associations, agricultural employers, or farm labor contractors, as defined in section 3 of the Migrant and Seasonal Agricultural Worker Protection Act, Public Law 97-470 (29 U.S.C. 1802). An “employee” is a person who performs labor or services in the United States for an employer in return for wages or other remuneration. The term “Employee” does not include those who do not receive any form of remuneration (volunteers), independent contractors or those engaged in certain casual domestic employment. Form I-9 has three sections. Employees complete Section 1. Employers complete Section 2 and, when applicable, Section 3. Employers may be fined if the form is not properly completed. See 8 USC § 1324a and 8 CFR § 274a.10. Individuals may be prosecuted for knowingly and willfully entering false information on the form. Employers are responsible for retaining completed forms. **Do not mail completed forms to U.S. Citizenship and Immigration Services (USCIS) or Immigration and Customs Enforcement (ICE).**

These instructions will assist you in properly completing Form I-9. The employer must ensure that all pages of the instructions and Lists of Acceptable Documents are available, either in print or electronically, to all employees completing this form. When completing the form on a computer, the English version of the form includes specific instructions for each field and drop-down lists for universally used abbreviations and acceptable documents. To access these instructions, move the cursor over each field or click on the question mark symbol (?) within the field. Employers and employees can also access this full set of instructions at any time by clicking the Instructions button at the top of each page when completing the form on a computer that is connected to the Internet.

Employers and employees may choose to complete any or all sections of the form on paper or using a computer, or a combination of both. Forms I-9 obtained from the USCIS website are not considered electronic Forms I-9 under DHS regulations and, therefore, cannot be electronically signed. Therefore, regardless of the method you used to enter information into each field, you must print a hard copy of the form, then sign and date the hard copy by hand where required.

Employers can obtain a blank copy of Form I-9 from the USCIS website at <https://www.uscis.gov/i-9>. This form is in portable document format (.pdf) that is fillable and savable. That means that you may download it, or simply print out a blank copy to enter information by hand. You may also request paper Forms I-9 from USCIS.

Certain features of Form I-9 that allow for data entry on personal computers may make the form appear to be more than two pages. When using a computer, Form I-9 has been designed to print as two pages. Using more than one preparer and/or translator will add an additional page to the form, regardless of your method of completion. You are not required to print, retain or store the page containing the Lists of Acceptable Documents.

The form will also populate certain fields with N/A when certain user choices ensure that particular fields will not be completed. The Print button located at the top of each page that will print any number of pages the user selects. Also, the Start Over button located at the top of each page will clear all the fields on the form.

The Spanish version of Form I-9 does not include the additional instructions and drop-down lists described above. Employers in Puerto Rico may use either the Spanish or English version of the form. Employers outside of Puerto Rico must retain the English version of the form for their records, but may use the Spanish form as a translation tool. Additional guidance to complete the form may be found in the [Handbook for Employers: Guidance for Completing Form I-9 \(M-274\)](#) and on USCIS' Form I-9 website, [I-9 Central](#).

Completing Section I: Employee Information and Attestation

You, the employee, must complete each field in Section 1 as described below. Newly hired employees must complete and sign Section 1 no later than the first day of employment. Section 1 should never be completed before you have accepted a job offer.

Entering Your Employee Information

Last Name (Family Name): Enter your full legal last name. Your last name is your family name or surname. If you have two last names or a hyphenated last name, include both names in the Last Name field. *Examples of correctly entered last names include: De La Cruz, O'Neill, Garcia Lopez, Smith-Johnson, Nguyen.* If you only have one name, enter it in this field, then enter "Unknown" in the First Name field. You may not enter "Unknown" in both the Last Name field and the First Name field.

First Name (Given Name): Enter your full legal first name. Your first name is your given name. *Some examples of correctly entered first names include: Jessica, John-Paul, Tae Young, D'Shaun, Mai.* If you only have one name, enter it in the Last Name field, then enter "Unknown" in this field. You may not enter "Unknown" in both the First Name field and the Last Name field.

Middle Initial: Your middle initial is the first letter of your second given name, or the first letter of your middle name, if any. If you have more than one middle name, enter the first letter of your first middle name. If you do not have a middle name, enter N/A in this field.

Other Last Names Used: Provide all other last names used, if any (e.g., maiden name). Enter N/A if you have not used other last names. For example, if you legally changed your last name from Smith to Jones, you should enter the name Smith in this field.

Address (Street Name and Number): Enter the street name and number of the current address of your residence. If you are a border commuter from Canada or Mexico, you may enter your Canada or Mexico address in this field. If your residence does not have a physical address, enter a description of the location of your residence, such as "3 miles southwest of Anytown post office near water tower."

Apartment: Enter the number(s) or letter(s) that identify(ies) your apartment. If you do not live in an apartment, enter N/A.

City or Town: Enter your city, town or village in this field. If your residence is not located in a city, town or village, enter your county, township, reservation, etc., in this field. If you are a border commuter from Canada, enter your city and province in this field. If you are a border commuter from Mexico, enter your city and state in this field.

State: Enter the abbreviation of your state or territory in this field. If you are a border commuter from Canada or Mexico, enter your country abbreviation in this field.

ZIP Code: Enter your 5-digit ZIP code. If you are a border commuter from Canada or Mexico, enter your 5- or 6-digit postal code in this field.

Date of Birth (mm/dd/yyyy): Enter your date of birth as a 2-digit month, 2-digit day, and 4-digit year (mm/dd/yyyy). For example, enter January 8, 1980 as 01/08/1980.

U.S. Social Security Number: Providing your 9-digit Social Security number is voluntary on Form I-9 unless your employer participates in E-Verify. If your employer participates in E-Verify and:

1. You have been issued a Social Security number, you must provide it in this field; or
2. You have applied for, but have not yet received a Social Security number, leave this field blank until you receive a Social Security number.

Employee's E-mail Address (Optional): Providing your e-mail address is optional on Form I-9, but the field cannot be left blank. To enter your e-mail address, use this format: name@site.domain. One reason Department of Homeland Security (DHS) may e-mail you is if your employer uses E-Verify and DHS learns of a potential mismatch between the information provided and the information in government records. This e-mail would contain information on how to begin to resolve the potential mismatch. You may use either your personal or work e-mail address in this field. Enter N/A if you do not enter your e-mail address.

Employee's Telephone Number (Optional): Providing your telephone number is optional on Form I-9, but the field cannot be left blank. If you enter your area code and telephone number, use this format: 000-000-0000. Enter N/A if you do not enter your telephone number.

Attesting to Your Citizenship or Immigration Status

You must select one box to attest to your citizenship or immigration status.

- 1. A citizen of the United States.**
- 2. A noncitizen national of the United States:** An individual born in American Samoa, certain former citizens of the former Trust Territory of the Pacific Islands, and certain children of noncitizen nationals born abroad.
- 3. A lawful permanent resident:** An individual who is not a U.S. citizen and who resides in the United States under legally recognized and lawfully recorded permanent residence as an immigrant. This term includes conditional residents. Asylees and refugees should not select this status, but should instead select "An Alien authorized to work" below.

If you select "lawful permanent resident," enter your 7- to 9-digit Alien Registration Number (A-Number), including the "A," or USCIS Number in the space provided. When completing this field using a computer, use the dropdown provided to indicate whether you have entered an Alien Number or a USCIS Number. At this time, the USCIS Number is the same as the A-Number without the "A" prefix.

- 4. An alien authorized to work:** An individual who is not a citizen or national of the United States, or a lawful permanent resident, but is authorized to work in the United States.

If you select this box, enter the date that your employment authorization expires, if any, in the space provided. In most cases, your employment authorization expiration date is found on the document(s) evidencing your employment authorization. Refugees, asylees and certain citizens of the Federated States of Micronesia, the Republic of the Marshall Islands, or Palau, and other aliens whose employment authorization does not have an expiration date should enter N/A in the Expiration Date field. In some cases, such as if you have Temporary Protected Status, your employment authorization may have been automatically extended; in these cases, you should enter the expiration date of the automatic extension in this space.

Aliens authorized to work must enter one of the following to complete Section 1:

1. Alien Registration Number (A-Number)/USCIS Number; or
2. Form I-94 Admission Number; or
3. Foreign Passport Number and the Country of Issuance.

Your employer may not ask you to present the document from which you supplied this information.

Alien Registration Number/USCIS Number: Enter your 7- to 9-digit Alien Registration Number (A-Number), including the "A," or your USCIS Number in this field. At this time, the USCIS Number is the same as your A-Number without the "A" prefix. When completing this field using a computer, use the dropdown provided to indicate whether you have entered an Alien Number or a USCIS Number. If you do not provide an A-Number or USCIS Number, enter N/A in this field then enter either a Form I-94 Admission Number, or a Foreign Passport and Country of Issuance in the fields provided.

Form I-94 Admission Number: Enter your 11-digit I-94 Admission Number in this field. If you do not provide an I-94 Admission Number, enter N/A in this field, then enter either an Alien Registration Number/USCIS Number or a Foreign Passport Number and Country of Issuance in the fields provided.

Foreign Passport Number: Enter your Foreign Passport Number in this field. If you do not provide a Foreign Passport Number, enter N/A in this field, then enter either an Alien Number/USCIS Number or a I-94 Admission Number in the fields provided.

Country of Issuance: If you entered your Foreign Passport Number, enter your Foreign Passport's Country of Issuance. If you did not enter your Foreign Passport Number, enter N/A.

Signature of Employee: After completing Section 1, sign your name in this field. If you used a form obtained from the USCIS website, you must print the form to sign your name in this field. By signing this form, you attest under penalty of perjury (28 U.S.C. § 1746) that the information you provided, along with the citizenship or immigration status you selected, and all information and documentation you provide to your employer, is complete, true and correct, and you are aware that you may face severe penalties provided by law and may be subject to criminal prosecution for knowingly and willfully making false statements or using false documentation when completing this form. Further, falsely attesting to U.S. citizenship may subject employees to penalties, removal proceedings and may adversely affect an employee's ability to seek future immigration benefits. If you cannot sign your name, you may place a mark in this field to indicate your signature. Employees who use a preparer or translator to help them complete the form must still sign or place a mark in the Signature of Employee field on the printed form.

If you used a preparer, translator, and other individual to assist you in completing Form I-9:

- Both you and your preparer(s) and/or translator(s) must complete the appropriate areas of Section 1, and then sign Section 1. If Section 1 was completed on a form obtained from the USCIS website, the form must be printed to sign these fields. You and your preparer(s) and/or translator(s) also should review the instructions for **Completing the Preparer and/or Translator Certification** below.
- If the employee is a minor (individual under 18) who cannot present an identity document, the employee's parent or legal guardian can complete Section 1 for the employee and enter "minor under age 18" in the signature field. If Section 1 was completed on a form obtained from the USCIS website, the form must be printed to enter this information. The minor's parent or legal guardian should review the instructions for Completing the Preparer and/or Translator Certification below. Refer to the [Handbook for Employers: Guidance for Completing Form I-9 \(M-274\)](#) for more guidance on completion of Form I-9 for minors. If the minor's employer participates in E-Verify, the employee must present a list B identity document with a photograph to complete Form I-9.
- If the employee is a person with a disability (who is placed in employment by a nonprofit organization, association or as part of a rehabilitation program) who cannot present an identity document, the employee's parent, legal guardian or a representative of the nonprofit organization, association or rehabilitation program can complete Section 1 for the employee and enter "Special Placement" in this field. If Section 1 was completed on a form obtained from the USCIS website, the form must be printed to enter this information. The parent, legal guardian or representative of the nonprofit organization, association or rehabilitation program completing Section 1 for the employee should review the instructions for Completing the Preparer and/or Translator Certification below. Refer to the [Handbook for Employers: Guidance for Completing Form I-9 \(M-274\)](#) for more guidance on completion of Form I-9 for certain employees with disabilities.

Today's Date: Enter the date you signed Section 1 in this field. Do not backdate this field. Enter the date as a 2-digit month, 2-digit day and 4-digit year (mm/dd/yyyy). For example, enter January 8, 2014 as 01/08/2014. A preparer or translator who assists the employee in completing Section 1 may enter the date the employee signed or made a mark to sign Section 1 in this field. Parents or legal guardians assisting minors (individuals under age 18) and parents, legal guardians or representatives of a nonprofit organization, association or rehabilitation program assisting certain employees with disabilities must enter the date they completed Section 1 for the employee.

Completing the Preparer and/or Translator Certification

If you did not use a preparer or translator to assist you in completing Section 1, you, the employee, must check the box marked **I did not use a Preparer or Translator**. If you check this box, leave the rest of the fields in this area blank.

If one or more preparers and/or translators assist the employee in completing the form using a computer, the preparer and/or translator must check the box marked "**A preparer(s) and/or translator(s) assisted the employee in completing Section 1**", then select the number of Certification areas needed from the dropdown provided. Any additional Certification areas generated will result in an additional page. [The Form I-9 Supplement](#), Section 1 Preparer and/or Translator Certification, can be separately downloaded from the USCIS Form I-9 webpage, which provides additional Certification areas for those completing Form I-9 using a computer who need more Certification areas than the 5 provided or those who are completing Form I-9 on paper. The first preparer and/or translator must complete all the fields in the Certification area on the same page the employee has signed. There is no limit to the number of preparers and/or translators an employee can use, but each additional preparer and/or translator must complete and sign a separate Certification area. Ensure the employee's last name, first name and middle initial are entered at the top of any additional pages. The employer must ensure that any additional pages are retained with the employee's completed Form I-9.

Signature of Preparer or Translator: Any person who helped to prepare or translate Section 1 of Form I-9 must sign his or her name in this field. If you used a form obtained from the USCIS website, you must print the form to sign your name in this field. The Preparer and/or Translator Certification must also be completed if “Individual under Age 18” or “Special Placement” is entered in lieu of the employee’s signature in Section 1.

Today's Date: The person who signs the Preparer and/or Translator Certification must enter the date he or she signs in this field on the printed form. Do not backdate this field. Enter the date as a 2-digit month, 2-digit day, and 4-digit year (mm/dd/yyyy). For example, enter January 8, 2014 as 01/08/2014.

Last Name (*Family Name*): Enter the full legal last name of the person who helped the employee in preparing or translating Section 1 in this field. The last name is also the family name or surname. If the preparer or translator has two last names or a hyphenated last name, include both names in this field.

First Name (*Given Name*): Enter the full legal first name of the person who helped the employee in preparing or translating Section 1 in this field. The first name is also the given name.

Address (*Street Name and Number*): Enter the street name and number of the current address of the residence of the person who helped the employee in preparing or translating Section 1 in this field. Addresses for residences in Canada or Mexico may be entered in this field. If the residence does not have a physical address, enter a description of the location of the residence, such as “3 miles southwest of Anytown post office near water tower.” If the residence is an apartment, enter the apartment number in this field.

City or Town: Enter the city, town or village of the residence of the person who helped the employee in preparing or translating Section 1 in this field. If the residence is not located in a city, town or village, enter the name of the county, township, reservation, etc., in this field. If the residence is in Canada, enter the city and province in this field. If the residence is in Mexico, enter the city and state in this field.

State: Enter the abbreviation of the state, territory or country of the preparer or translator’s residence in this field.

ZIP Code: Enter the 5-digit ZIP code of the residence of the person who helped the employee in preparing or translating Section 1 in this field. If the preparer or translator's residence is in Canada or Mexico, enter the 5- or 6-digit postal code.

Presenting Form I-9 Documents

Within 3 business days of starting work for pay, you must present to your employer documentation that establishes your identity and employment authorization. For example, if you begin employment on Monday, you must present documentation on or before Thursday of that week. However, if you were hired to work for less than 3 business days, you must present documentation no later than the first day of employment.

Choose which unexpired document(s) to present to your employer from the Lists of Acceptable Documents. An employer cannot specify which document(s) you may present from the Lists of Acceptable Documents. You may present either one selection from List A or a combination of one selection from List B and one selection from List C. Some List A documents, which show both identity and employment authorization, are combination documents that must be presented together to be considered a List A document: for example, the foreign passport together with a Form I-94 containing an endorsement of the alien’s nonimmigrant status and employment authorization with a specific employer incident to such status. List B documents show identity only and List C documents show employment authorization only. If your employer participates in E-Verify and you present a List B document, the document must contain a photograph. If you present acceptable List A documentation, you should not be asked to present, nor should you provide, List B and List C documentation. If you present acceptable List B and List C documentation, you should not be asked to present, nor should you provide, List A documentation. If you are unable to present a document(s) from these lists, you may be able to present an acceptable receipt. Refer to the Receipts section below.

Your employer must review the document(s) you present to complete Form I-9. If your document(s) reasonably appears to be genuine and to relate to you, your employer must accept the documents. If your document(s) does not reasonably appear to be genuine or to relate to you, your employer must reject it and provide you with an opportunity to present other documents from the Lists of Acceptable Documents. Your employer may choose to make copies of your document(s), but must return the original(s) to you. Your employer must review your documents in your physical presence.

Your employer will complete the other parts of this form, as well as review your entries in Section 1. Your employer may ask you to correct any errors found. Your employer is responsible for ensuring all parts of Form I-9 are properly completed and is subject to penalties under federal law if the form is not completed correctly.

Minors (individuals under age 18) and certain employees with disabilities whose parent, legal guardian or representative completed Section 1 for the employee are only required to present an employment authorization document from List C. Refer to the [Handbook for Employers: Guidance for Completing Form I-9 \(M-274\)](#) for more guidance on minors and certain individuals with disabilities.

Receipts

If you do not have unexpired documentation from the Lists of Acceptable Documents, you may be able to present a receipt(s) in lieu of an acceptable document(s). New employees who choose to present a receipt(s) must do so within three business days of their first day of employment. If your employer is reverifying your employment authorization, and you choose to present a receipt for reverification, you must present the receipt by the date your employment authorization expires. Receipts are not acceptable if employment lasts fewer than three business days.

There are three types of acceptable receipts:

1. A receipt showing that you have applied to replace a document that was lost, stolen or damaged. You must present the actual document within 90 days from the date of hire or, in the case of reverification, within 90 days from the date your original employment authorization expires.
2. The arrival portion of Form I-94/I-94A containing a temporary I-551 stamp and a photograph of the individual. You must present the actual Permanent Resident Card (Form I-551) by the expiration date of the temporary I-551 stamp, or, if there is no expiration date, within 1 year from the date of admission.
3. The departure portion of Form I-94/I-94A with a refugee admission stamp. You must present an unexpired Employment Authorization Document (Form I-766) or a combination of a List B document and an unrestricted Social Security Card within 90 days from the date of hire or, in the case of reverification, within 90 days from the date your original employment authorization expires.

Receipts showing that you have applied for an initial grant of employment authorization, or for renewal of your expiring or expired employment authorization, are not acceptable.

Completing Section 2: Employer or Authorized Representative Review and Verification

You, the employer, must ensure that all parts of Form I-9 are properly completed and may be subject to penalties under federal law if the form is not completed correctly. Section 1 must be completed no later than the employee's first day of employment. You may not ask an individual to complete Section 1 before he or she has accepted a job offer. Before completing Section 2, you should review Section 1 to ensure the employee completed it properly. If you find any errors in Section 1, have the employee make corrections, as necessary and initial and date any corrections made.

You may designate an authorized representative to act on your behalf to complete Section 2. An authorized representative can be any person you designate to complete and sign Form I-9 on your behalf. You are liable for any violations in connection with the form or the verification process, including any violations of the employer sanctions laws committed by the person designated to act on your behalf.

You or your authorized representative must complete Section 2 by examining evidence of identity and employment authorization within 3 business days of the employee's first day of employment. For example, if an employee begins employment on Monday, you must review the employee's documentation and complete Section 2 on or before Thursday of that week. However, if you hire an individual for less than 3 business days, Section 2 must be completed no later than the first day of employment.

Entering Employee Information from Section 1

This area, titled, "Employee Info from Section 1" contains fields to enter the employee's last name, first name, middle initial exactly as he or she entered them in Section 1. This area also includes a Citizenship/Immigration Status field to enter the number of the citizenship or immigration status checkbox the employee selected in Section 1. These fields help to ensure that the two pages of an employee's Form I-9 remain together. When completing Section 2 using a computer, the number entered in the Citizenship/Immigration Status field provides drop-downs that directly relate to the employee's selected citizenship or immigration status.

Entering Documents the Employee Presents

You, the employer or authorized representative, must physically examine, in the employee's physical presence, the unexpired document(s) the employee presents from the Lists of Acceptable Documents to complete the Document fields in Section 2.

You cannot specify which document(s) an employee may present from these lists. If you discriminate in the Form I-9 process based on an individual's citizenship status, immigration status, or national origin, you may be in violation of the law and subject to sanctions such as civil penalties and be required to pay back pay to discrimination victims. A document is acceptable as long as it reasonably appears to be genuine and to relate to the person presenting it. Employees must present one selection from List A or a combination of one selection from List B and one selection from List C.

List A documents show both identity and employment authorization. Some List A documents are combination documents that must be presented together to be considered a List A document, such as a foreign passport together with a Form I-94 containing an endorsement of the alien's nonimmigrant status.

List B documents show identity only, and List C documents show employment authorization only. If an employee presents a List A document, do not ask or require the employee to present List B and List C documents, and vice versa. If an employer participates in E-Verify and the employee presents a List B document, the List B document must include a photograph.

If an employee presents a receipt for the application to replace a lost, stolen or damaged document, the employee must present the replacement document to you within 90 days of the first day of work for pay, or in the case of reverification, within 90 days of the date the employee's employment authorization expired. Enter the word "Receipt" followed by the title of the receipt in Section 2 under the list that relates to the receipt.

When your employee presents the replacement document, draw a line through the receipt, then enter the information from the new document into Section 2. Other receipts may be valid for longer or shorter periods, such as the arrival portion of Form I-94/I-94A containing a temporary I-551 stamp and a photograph of the individual, which is valid until the expiration date of the temporary I-551 stamp or, if there is no expiration date, valid for one year from the date of admission.

Ensure that each document is an unexpired, original (no photocopies, except for certified copies of birth certificates) document. Certain employees may present an expired employment authorization document, which may be considered unexpired, if the employee's employment authorization has been extended by regulation or a Federal Register Notice. Refer to the [Handbook for Employers: Guidance for Completing Form I-9 \(M-274\)](#) or [I-9 Central](#) for more guidance on these special situations.

Refer to the M-274 for guidance on how to handle special situations, such as students (who may present additional documents not specified on the Lists) and H-1B and H-2A nonimmigrants changing employers.

Minors (individuals under age 18) and certain employees with disabilities whose parent, legal guardian or representative completed Section 1 for the employee are only required to present an employment authorization document from List C. Refer to the M-274 for more guidance on minors and certain persons with disabilities. If the minor's employer participates in E-Verify, the minor employee also must present a List B identity document with a photograph to complete Form I-9.

You must return original document(s) to the employee, but may make photocopies of the document(s) reviewed. Photocopying documents is voluntary unless you participate in E-Verify. E-Verify employers are only required to photocopy certain documents. If you are an E-Verify employer who chooses to photocopy documents other than those you are required to photocopy, you should apply this policy consistently with respect to Form I-9 completion for all employees. For more information on the types of documents that an employer must photocopy if the employer uses E-Verify, visit E-Verify's website at www.everify.gov. For non-E-Verify employers, if photocopies are made, they should be made consistently for ALL new hires and reverified employees.

Photocopies must be retained and presented with Form I-9 in case of an inspection by DHS or another federal government agency. You must always complete Section 2 by reviewing original documentation, even if you photocopy an employee's document(s) after reviewing the documentation. Making photocopies of an employee's document(s) cannot take the place of completing Form I-9. You are still responsible for completing and retaining Form I-9.

List A - Identity and Employment Authorization: If the employee presented an acceptable document(s) from List A or an acceptable receipt for a List A document, enter the document(s) information in this column. If the employee presented a List A document that consists of a combination of documents, enter information from each document in that combination in a separate area under List A as described below. All documents must be unexpired. If you enter document information in the List A column, you should not enter document information or N/A in the List B or List C columns. If you complete Section 2 using a computer, a selection in List A will fill all the fields in the Lists B and C columns with N/A.

Document Title: If the employee presented a document from List A, enter the title of the List A document or receipt in this field. The abbreviations provided are available in the dropdown when the form is completed on a computer. When completing the form on paper, you may choose to use these abbreviations or any other common abbreviation to enter the document title or issuing authority. If the employee presented a combination of documents, use the second and third Document Title fields as necessary.

Full name of List A Document	Abbreviations
U.S. Passport	U.S. Passport
U.S. Passport Card	U.S. Passport Card
Permanent Resident Card (Form I-551)	Perm. Resident Card (Form I-551)
Alien Registration Receipt Card (Form I-551)	Alien Reg. Receipt Card (Form I-551)
Foreign passport containing a temporary I-551 stamp	1. Foreign Passport 2. Temporary I-551 Stamp
Foreign passport containing a temporary I-551 printed notation on a machine-readable immigrant visa (MRIV)	1. Foreign Passport 2. Machine-readable immigrant visa (MRIV)
Employment Authorization Document (Form I-766)	Employment Auth. Document (Form I-766)
For a nonimmigrant alien authorized to work for a specific employer because of his or her status, a foreign passport with Form I-94/I-94A that contains an endorsement of the alien's nonimmigrant status	1. Foreign Passport, work-authorized non-immigrant 2. Form I-94/I-94A 3. Form I-20 or Form DS-2019 Note: In limited circumstances, certain J-1 students may be required to present a letter from their Responsible Officer in order to work. Enter the document title, issuing authority, document number and expiration date from this document in the Additional Information field.
Passport from the Federated States of Micronesia (FSM) with Form I-94/I-94A	1. FSM Passport with Form I-94 2. Form I-94/I-94A
Passport from the Republic of the Marshall Islands (RMI) with Form I-94/I-94A	1. RMI Passport with Form I-94 2. Form I-94/I-94A
Receipt: The arrival portion of Form I-94/I-94A containing a temporary I-551 stamp and photograph	Receipt: Form I-94/I-94A w/I-551 stamp, photo
Receipt: The departure portion of Form I-94/I-94A with an unexpired refugee admission stamp	Receipt: Form I-94/I-94A w/refugee stamp
Receipt for an application to replace a lost, stolen or damaged Permanent Resident Card (Form I-551)	Receipt replacement Perm. Res. Card (Form I-551)
Receipt for an application to replace a lost, stolen or damaged Employment Authorization Document (Form I-766)	Receipt replacement EAD (Form I-766)
Receipt for an application to replace a lost, stolen or damaged foreign passport with Form I-94/I-94A that contains an endorsement of the alien's nonimmigrant status	1. Receipt: Replacement Foreign Passport, work-authorized nonimmigrant 2. Receipt: Replacement Form I-94/I-94A 3. Form I-20 or Form DS-2019 (if presented)
Receipt for an application to replace a lost, stolen or damaged passport from the Federated States of Micronesia with Form I-94/I-94A	1. Receipt: Replacement FSM Passport with Form I-94 2. Receipt: Replacement Form I-94/I-94A
Receipt for an application to replace a lost, stolen or damaged passport from the Republic of the Marshall Islands with Form I-94/I-94A	1. Receipt: Replacement RMI Passport with Form I-94 2. Receipt: Replacement Form I-94/I-94A

Issuing Authority: Enter the issuing authority of the List A document or receipt. The issuing authority is the specific entity that issued the document. If the employee presented a combination of documents, use the second and third Issuing Authority fields as necessary.

Document Number: Enter the document number, if any, of the List A document or receipt presented. If the document does not contain a number, enter N/A in this field. If the employee presented a combination of documents, use the second and third Document Number fields as necessary. If the document presented was a Form I-20 or DS-2019, enter the Student and Exchange Visitor Information System (SEVIS) number in the third Document Number field exactly as it appears on the Form I-20 or the DS-2019.

Expiration Date (if any) (mm/dd/yyyy): Enter the expiration date, if any, of the List A document. The document is not acceptable if it has already expired. If the document does not contain an expiration date, enter N/A in this field. If the document uses text rather than a date to indicate when it expires, enter the text as shown on the document, such as "D/S" (which means, "duration of status"). For a receipt, enter the expiration date of the receipt validity period as described above. If the employee presented a combination of documents, use the second and third Expiration Date fields as necessary. If the document presented was a Form I-20 or DS-2019, enter the program end date here.

List B - Identity: If the employee presented an acceptable document from List B or an acceptable receipt for the application to replace a lost, stolen, or destroyed List B document, enter the document information in this column. If a parent or legal guardian attested to the identity of an employee who is an [individual under age 18](#) or certain [employees with disabilities](#) in Section 1, enter either "Individual under age 18" or "Special Placement" in this field. Refer to the [Handbook for Employers: Guidance for Completing Form I-9 \(M-274\)](#) for more guidance on individuals under age 18 and certain person with disabilities.

If you enter document information in the List B column, you must also enter document information in the List C column. If an employee presents acceptable List B and List C documents, do not ask the employees to present a List A document. If you enter document information in List B, you should not enter document information or N/A in List A. If you complete Section 2 using a computer, a selection in List B will fill all the fields in the List A column with N/A.

Document Title: If the employee presented a document from List B, enter the title of the List B document or receipt in this field. The abbreviations provided are available in the dropdown when the form is completed on a computer. When completing the form on paper, you may choose to use these abbreviations or any other common abbreviations to document the document title or issuing authority.

Full name of List B Document	Abbreviations
Driver's license issued by a State or outlying possession of the United States	Driver's license issued by state/territory
ID card issued by a State or outlying possession of the United States	ID card issued by state/territory
ID card issued by federal, state, or local government agencies or entities (Note: This selection does not include the driver's license or ID card issued by a State or outlying possession of the United States as described in B1 of the List of Acceptable Documents.)	Government ID
School ID card with photograph	School ID
Voter's registration card	Voter registration card
U.S. Military card	U.S. Military card
U.S. Military draft record	U.S. Military draft record
Military dependent's ID card	Military dependent's ID card
U.S. Coast Guard Merchant Mariner Card	USCG Merchant Mariner card
Native American tribal document	Native American tribal document
Driver's license issued by a Canadian government authority	Canadian driver's license
School record (for persons under age 18 who are unable to present a document listed above)	School record (under age 18)
Report card (for persons under age 18 who are unable to present a document listed above)	Report card (under age 18)
Clinic record (for persons under age 18 who are unable to present a document listed above)	Clinic record (under age 18)
Doctor record (for persons under age 18 who are unable to present a document listed above)	Doctor record (under age 18)
Hospital record (for persons under age 18 who are unable to present a document listed above)	Hospital record (under age 18)
Day-care record (for persons under age 18 who are unable to present a document listed above)	Day-care record (under age 18)
Nursery school record (for persons under age 18 who are unable to present a document listed above)	Nursery school record (under age 18)

Full name of List B Document	Abbreviations
Individual under age 18 endorsement by parent or guardian	Individual under Age 18
Special placement endorsement for persons with disabilities	Special Placement
Receipt for the application to replace a lost, stolen or damaged Driver's License issued by a State or outlying possession of the United States	Receipt: Replacement driver's license
Receipt for the application to replace a lost, stolen or damaged ID card issued by a State or outlying possession of the United States	Receipt: Replacement ID card
Receipt for the application to replace a lost, stolen or damaged ID card issued by federal, state, or local government agencies or entities	Receipt: Replacement Gov't ID
Receipt for the application to replace a lost, stolen or damaged School ID card with photograph	Receipt: Replacement School ID
Receipt for the application to replace a lost, stolen or damaged Voter's registration card	Receipt: Replacement Voter reg. card
Receipt for the application to replace a lost, stolen or damaged U.S. Military card	Receipt: Replacement U.S. Military card
Receipt for the application to replace a lost, stolen or damaged Military dependent's ID card	Receipt: Replacement U.S. Military dep. card
Receipt for the application to replace a lost, stolen or damaged U.S. Military draft record	Receipt: Replacement Military draft record
Receipt for the application to replace a lost, stolen or damaged U.S. Coast Guard Merchant Mariner Card	Receipt: Replacement Merchant Mariner card
Receipt for the application to replace a lost, stolen or damaged Driver's license issued by a Canadian government authority	Receipt: Replacement Canadian DL
Receipt for the application to replace a lost, stolen or damaged Native American tribal document	Receipt: Replacement Native American tribal doc
Receipt for the application to replace a lost, stolen or damaged School record (for persons under age 18 who are unable to present a document listed above)	Receipt: Replacement School record (under age 18)
Receipt for the application to replace a lost, stolen or damaged Report card (for persons under age 18 who are unable to present a document listed above)	Receipt: Replacement Report card (under age 18)
Receipt for the application to replace a lost, stolen or damaged Clinic record (for persons under age 18 who are unable to present a document listed above)	Receipt: Replacement Clinic record (under age 18)
Receipt for the application to replace a lost, stolen or damaged Doctor record (for persons under age 18 who are unable to present a document listed above)	Receipt: Replacement Doctor record (under age 18)
Receipt for the application to replace a lost, stolen or damaged Hospital record (for persons under age 18 who are unable to present a document listed above)	Receipt: Replacement Hospital record (under age 18)
Receipt for the application to replace a lost, stolen or damaged Day-care record (for persons under age 18 who are unable to present a document listed above)	Receipt: Replacement Day-care record (under age 18)
Receipt for the application to replace a lost, stolen or damaged Nursery school record (for persons under age 18 who are unable to present a document listed above)	Receipt: Replacement Nursery school record (under age 18)

Issuing Authority: Enter the issuing authority of the List B document or receipt. The issuing authority is the entity that issued the document. If the employee presented a document that is issued by a state agency, include the state as part of the issuing authority.

Document Number: Enter the document number, if any, of the List B document or receipt exactly as it appears on the document. If the document does not contain a number, enter N/A in this field.

Expiration Date (if any) (mm/dd/yyyy): Enter the expiration date, if any, of the List B document. The document is not acceptable if it has already expired. If the document does not contain an expiration date, enter N/A in this field. For a receipt, enter the expiration date of the receipt validity period as described in the Receipt section above.

List C - Employment Authorization: If the employee presented an acceptable document from List C, or an acceptable receipt for the application to replace a lost, stolen, or destroyed List C document, enter the document information in this column. If you enter document information in the List C column, you must also enter document information in the List B column. If an employee presents acceptable List B and List C documents, do not ask the employee to present a list A document. If you enter document information in List C, you should not enter document information or N/A in List A. If you complete Section 2 using a computer, a selection in List C will fill all the fields in the List A column with N/A.

Document Title: If the employee presented a document from List C, enter the title of the List C document or receipt in this field. The abbreviations provided are available in the dropdown when the form is completed on a computer. When completing the form on paper, you may choose to use these abbreviations or any other common abbreviations to document the document title or issuing authority. If you are completing the form on a computer, and you select an Employment authorization document issued by DHS, the field will populate with List C #7 and provide a space for you to enter a description of the documentation the employee presented. Refer to the M-274 for guidance on entering List C #7 documentation.

Full name of List C Document	Abbreviations
Social Security Account Number card without restrictions	(Unrestricted) Social Security Card
Certification of Birth Abroad (Form FS-545)	Form FS-545
Certification of Report of Birth (Form DS-1350)	Form DS-1350
Consular Report of Birth Abroad (Form FS-240)	Form FS-240
Original or certified copy of a U.S. birth certificate bearing an official seal	Birth Certificate
Native American tribal document	Native American tribal document
U.S. Citizen ID Card (Form I-197)	Form I-197
Identification Card for use of Resident Citizen in the United States (Form I-179)	Form I-179
Employment authorization document issued by DHS (List C #7) (Note: This selection does not include the Employment Authorization Document (Form I-766) from List A.)	Employment Auth. document (DHS) List C #7
Receipt for the application to replace a lost, stolen or damaged Social Security Account Number Card without restrictions	Receipt: Replacement Unrestricted SS Card
Receipt for the application to replace a lost, stolen or damaged Original or certified copy of a U.S. birth certificate bearing an official seal	Receipt: Replacement Birth Certificate
Receipt for the application to replace a lost, stolen or damaged Native American Tribal Document	Receipt: Replacement Native American Tribal Doc.
Receipt for the application to replace a lost, stolen or damaged Employment Authorization Document issued by DHS	Receipt: Replacement Employment Auth. Doc. (DHS)

Issuing Authority: Enter the issuing authority of the List C document or receipt. The issuing authority is the entity that issued the document.

Document Number: Enter the document number, if any, of the List C document or receipt exactly as it appears on the document. If the document does not contain a number, enter N/A in this field.

Expiration Date (if any) (mm/dd/yyyy): Enter the expiration date, if any, of the List C document. The document is not acceptable if it has already expired, unless USCIS has extended the expiration date on the document. For instance, if a conditional resident presents a Form I-797 extending his or her conditional resident status with the employee's expired Form I-551, enter the future expiration date as indicated on the Form I-797. If the document has no expiration date, enter N/A in this field. For a receipt, enter the expiration date of the receipt validity period as described in the Receipt section above.

Additional Information: Use this space to notate any additional information required for Form I-9 such as:

- Employment authorization extensions for Temporary Protected Status beneficiaries, F-1 OPT STEM students, CAP-GAP, H-1B and H-2A employees continuing employment with the same employer or changing employers, and other nonimmigrant categories that may receive extensions of stay
- Additional document(s) that certain nonimmigrant employees may present
- Discrepancies that E-Verify employers must notate when participating in the IMAGE program
- Employee termination dates and form retention dates
- E-Verify case number, which may also be entered in the margin or attached as a separate sheet per E-Verify requirements and your chosen business process
- Any other comments or notations necessary for the employer's business process

You may leave this field blank if the employee's circumstances do not require additional notations.

Entering Information in the Employer Certification

Employee's First Day of Employment: Enter the employee's first day of employment as a 2-digit month, 2-digit day and 4-digit year (mm/dd/yyyy).

Signature of Employer or Authorized Representative: Review the form for accuracy and completeness. The person who physically examines the employee's original document(s) and completes Section 2 must sign his or her name in this field. If you used a form obtained from the USCIS website, you must print the form to sign your name in this field. By signing Section 2, you attest under penalty of perjury (28 U.S.C. § 1746) that you have physically examined the documents presented by the employee, the document(s) reasonably appear to be genuine and to relate to the employee named, that to the best of your knowledge the employee is authorized to work in the United States, that the information you entered in Section 2 is complete, true and correct to the best of your knowledge, and that you are aware that you may face severe penalties provided by law and may be subject to criminal prosecution for knowingly and willfully making false statements or knowingly accepting false documentation when completing this form.

Today's Date: The person who signs Section 2 must enter the date he or she signed Section 2 in this field. Do not backdate this field. If you used a form obtained from the USCIS website, you must print the form to write the date in this field. Enter the date as a 2-digit month, 2-digit day and 4-digit year (mm/dd/yyyy). For example, enter January 8, 2014 as 01/08/2014.

Title of Employer or Authorized Representative: Enter the title, position or role of the person who physically examines the employee's original document(s), completes and signs Section 2.

Last Name of the Employer or Authorized Representative: Enter the full legal last name of the person who physically examines the employee's original documents, completes and signs Section 2. Last name refers to family name or surname. If the person has two last names or a hyphenated last name, include both names in this field.

First Name of the Employer or Authorized Representative: Enter the full legal first name of the person who physically examines the employee's original documents, completes, and signs Section 2. First name refers to the given name.

Employer's Business or Organization Name: Enter the name of the employer's business or organization in this field.

Employer's Business or Organization Address (*Street Name and Number*): Enter an actual, physical address of the employer. If your company has multiple locations, use the most appropriate address that identifies the location of the employer. Do not provide a P.O. Box address.

City or Town: Enter the city or town for the employer's business or organization address. If the location is not a city or town, you may enter the name of the village, county, township, reservation, etc, that applies.

State: Enter the two-character abbreviation of the state for the employer's business or organization address.

ZIP Code: Enter the 5-digit ZIP code for the employer's business or organization address.

Completing Section 3: Reverification and Rehires

Section 3 applies to both reverification and rehires. When completing this section, you must also complete the Last Name, First Name and Middle Initial fields in the Employee Info from Section 1 area at the top of Section 2, leaving the Citizenship/Immigration Status field blank. When completing Section 3 in either a reverification or rehire situation, if the employee's name has changed, record the new name in Block A.

Reverification

Reverification in Section 3 must be completed prior to the earlier of:

- The expiration date, if any, of the employment authorization stated in Section 1, or
- The expiration date, if any, of the List A or List C employment authorization document recorded in Section 2 (with some exceptions listed below).

Some employees may have entered "N/A" in the expiration date field in Section 1 if they are aliens whose employment authorization does not expire, e.g. asylees, refugees, certain citizens of the Federated States of Micronesia, the Republic of the Marshall Islands, or Palau. Reverification does not apply for such employees unless they choose to present evidence of employment authorization in Section 2 that contains an expiration date and requires reverification, such as Form I-766, Employment Authorization Document.

You should not reverify U.S. citizens and noncitizen nationals, or lawful permanent residents (including conditional residents) who presented a Permanent Resident Card (Form I-551). Reverification does not apply to List B documents.

For reverification, an employee must present an unexpired document(s) (or a receipt) from either List A or List C showing he or she is still authorized to work. You CANNOT require the employee to present a particular document from List A or List C. The employee is also not required to show the same type of document that he or she presented previously. See specific instructions on how to complete Section 3 below.

Rehires

If you rehire an employee within three years from the date that the Form I-9 was previously executed, you may either rely on the employee's previously executed Form I-9 or complete a new Form I-9.

If you choose to rely on a previously completed Form I-9, follow these guidelines.

- If the employee remains employment authorized as indicated on the previously executed Form I-9, the employee does not need to provide any additional documentation. Provide in Section 3 the employee's rehire date, any name changes if applicable, and sign and date the form.
- If the previously executed Form I-9 indicates that the employee's employment authorization from Section 1 or employment authorization documentation from Section 2 that is subject to reverification has expired, then reverification of employment authorization is required in Section 3 in addition to providing the rehire date. If the previously executed Form I-9 is not the current version of the form, you must complete Section 3 on the current version of the form.
- If you already used Section 3 of the employee's previously executed Form I-9, but are rehiring the employee within three years of the original execution of Form I-9, you may complete Section 3 on a new Form I-9 and attach it to the previously executed form.

Employees rehired after three years of original execution of the Form I-9 must complete a new Form I-9.

Complete each block in Section 3 as follows:

Block A - New Name: If an employee who is being reverified or rehired has also changed his or her name since originally completing Section 1 of this form, complete this block with the employee's new name. Enter only the part of the name that has changed, for example: if the employee changed only his or her last name, enter the last name in the Last Name field in this Block, then enter N/A in the First Name and Middle Initial fields. If the employee has not changed his or her name, enter N/A in each field of Block A.

Block B - Date of Rehire: Complete this block if you are rehiring an employee within three years of the date Form I-9 was originally executed. Enter the date of rehire in this field. Enter N/A in this field if the employee is not being rehired.

Block C - Complete this block if you are reverifying expiring or expired employment authorization or employment authorization documentation of a current or rehired employee. Enter the information from the List A or List C document(s) (or receipt) that the employee presented to reverify his or her employment authorization. All documents must be unexpired.

Document Title: Enter the title of the List A or C document (or receipt) the employee has presented to show continuing employment authorization in this field.

Document Number: Enter the document number, if any, of the document you entered in the Document Title field exactly as it appears on the document. Enter N/A if the document does not have a number.

Expiration Date (if any) (mm/dd/yyyy): Enter the expiration date, if any, of the document you entered in the Document Title field as a 2-digit month, 2-digit day, and 4-digit year (mm/dd/yyyy). If the document does not contain an expiration date, enter N/A in this field.

Signature of Employer or Authorized Representative: The person who completes Section 3 must sign in this field. If you used a form obtained from the USCIS website, you must print Section 3 of the form to sign your name in this field. By signing Section 3, you attest under penalty of perjury (28 U.S.C. §1746) that you have examined the documents presented by the employee, that the document(s) reasonably appear to be genuine and to relate to the employee named, that to the best of your knowledge the employee is authorized to work in the United States, that the information you entered in Section 3 is complete, true and correct to the best of your knowledge, and that you are aware that you may face severe penalties provided by law and may be subject to criminal prosecution for knowingly and willfully making false statements or knowingly accepting false documentation when completing this form.

Today's Date: The person who completes Section 3 must enter the date Section 3 was completed and signed in this field. Do not backdate this field. If you used a form obtained from the USCIS website, you must print Section 3 of the form to enter the date in this field. Enter the date as a 2-digit month, 2-digit day, and 4-digit year (mm/dd/yyyy). For example, enter January 8, 2014 as 01/08/2014.

Name of Employer or Authorized Representative: The person who completed, signed and dated Section 3 must enter his or her name in this field.

What is the Filing Fee?

There is no fee for completing Form I-9. This form is not filed with USCIS or any government agency. Form I-9 must be retained by the employer and made available for inspection by U.S. Government officials as specified in the "DHS Privacy Notice" below.

USCIS Forms and Information

For additional guidance about Form I-9, employers and employees should refer to the *Handbook for Employers: Guidance for Completing Form I-9 (M-274)* or USCIS' Form I-9 website at <https://www.uscis.gov/i-9-central>.

You can also obtain information about Form I-9 by e-mailing USCIS at I-9Central@dhs.gov, or by calling 1-888-464-4218 or 1-877-875-6028 (TTY).

You may download and obtain the English and Spanish versions of Form I-9, the *Handbook for Employers*, or the instructions to Form I-9 from the USCIS website at <https://www.uscis.gov/i-9>. To complete Form I-9 on a computer, you will need the latest version of Adobe Reader, which can be downloaded for free at <http://get.adobe.com/reader/>. You may order paper forms at <https://www.uscis.gov/forms/forms-by-mail> or by contacting the USCIS Contact Center at 1-800-375-5283 or 1-800-767-1833 (TTY).

Information about E-Verify, a web-based system that allows employers to confirm the eligibility of their employees to work in the United States, can be obtained at <https://www.e-verify.gov> or by contacting E-Verify at <https://www.e-verify.gov/contact-us>.

Employees with questions about Form I-9 and/or E-Verify can reach the USCIS employee hotline by calling 1-888-897-7781 or 1-877-875-6028 (TTY).

Photocopying Blank and Completed Forms I-9 and Retaining Completed Forms I-9

Employers may photocopy or print blank Forms I-9 for future use. All pages of the instructions and Lists of Acceptable Documents must be available, either in print or electronically, to all employees completing this form. Employers must retain each employee's completed Form I-9 for as long as the individual works for the employer and for a specified period after employment has ended. Employers are required to retain the pages of the form on which the employee and employer entered data. If copies of documentation presented by the employee are made, those copies must also be retained. Once the individual's employment ends, the employer must retain this form and attachments for either 3 years after the date of hire (i.e., first day of work for pay) or 1 year after the date employment ended, whichever is later. In the case of recruiters or referrers for a fee (only applicable to those that are agricultural associations, agricultural employers, or farm labor contractors), the retention period is 3 years after the date of hire (i.e., first day of work for pay).

Forms I-9 obtained from the USCIS website that are not printed and signed manually (by hand) are not considered complete. In the event of an inspection, retaining incomplete forms may make you subject to fines and penalties associated with incomplete forms.

Employers should ensure that information employees provide on Form I-9 is used only for Form I-9 purposes. Completed Forms I-9 and all accompanying documents should be stored in a safe, secure location.

Form I-9 may be generated, signed, and retained electronically, in compliance with Department of Homeland Security regulations at 8 CFR 274a.2.

DHS Privacy Notice

AUTHORITIES: The information requested on this form, and the associated documents, are collected under the Immigration Reform and Control Act of 1986, Pub. L. 99-603 (8 USC 1324a).

PURPOSE: The primary purpose for providing the requested information on this form is for employers to verify your identity and employment authorization. Consistent with the requirements of the Immigration Reform and Control Act of 1986, employers use the Form I-9 to document the verification of the identity and employment authorization for new employees to prevent the unlawful hiring, or recruiting or referring for a fee, of aliens who are not authorized to work in the United States. This form is completed by both the employer and employee, and is ultimately retained by the employer.

DISCLOSURE: The information you provide is voluntary. However, failure to provide the requested information, including your Social Security number (if applicable), and any requested evidence, may result in termination of employment. Failure of the employer to ensure proper completion of this form may result in the imposition of civil or criminal penalties against the employer. In addition, knowingly employing individuals who are not authorized to work in the United States may subject the employer to civil and/or criminal penalties.

ROUTINE USES: This information will be used by employers as a record of their basis for determining eligibility of an individual to work in the United States. The employer must retain this completed form and make it available for inspection by authorized officials of the Department of Homeland Security, Department of Labor, and Department of Justice, Civil Rights Division, Immigrant and Employee Rights Section. DHS may also share this information, as appropriate, for law enforcement purposes or in the interest of national security.

Paperwork Reduction Act

An agency may not conduct or sponsor an information collection and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. The public reporting burden for this collection of information is estimated at 35 minutes per response, when completing the form manually, and 26 minutes per response when using a computer to aid in completion of the form, including the time for reviewing instructions and completing and retaining the form. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to: U.S. Citizenship and Immigration Services, Regulatory Coordination Division, Office of Policy and Strategy, 20 Massachusetts Avenue NW, Washington, DC 20529-2140; OMB No. 1615-0047. **Do not mail your completed Form I-9 to this address.**

VOLUNTARY INFORMATION FOR GOVERNMENT MONITORING PURPOSES

This organization is an Equal Opportunity/Affirmative Action employer.

The information below is needed to measure the effectiveness of our recruitment efforts and is in conformity with federal government guidelines which require us to compile statistical information about applicants for employment. You are not required to furnish this information, but are encouraged to do so. The law provides that an employer may neither discriminate on the basis of this information, nor on whether you choose to furnish it. However, if you choose not to furnish it, under federal regulations, this employer is required to note race and sex on the basis of visual observation or surname.

The Voluntary Information Sheet will be kept in a confidential file separate from the application for Employment.

Position Applied for: _____

I wish to furnish this information (initials): _____

I do not wish to furnish this information (initials): _____

Please check the appropriate box: Male Female

ETHNIC CATEGORY (Check One)

_____ **WHITE (Not of Hispanic origin)** – All persons having origins in any of the original peoples of Europe, North Africa, or the Middle East.

_____ **BLACK (Not of Hispanic origin)** – All persons having origins in any of the Black racial groups of Africa.

_____ **ASIAN OR PACIFIC ISLANDER** – All persons having origins in any of the original peoples of the Far East, Southeast Asia and Indian Subcontinent, or the Pacific Islands. This areas includes, for example, China, Japan, Korea, the Philippine Islands and Samoa.

_____ **AMERICAN INDIAN OR ALASKA NATIVE** – All persons having origins in any of the original peoples of North America, and who maintain cultural identification through tribal affiliations or community recognition.

_____ **HISPANIC** – All persons of Mexican, Puerto Rican, Cuban, Central or south American, or other Spanish culture or origin, regardless of race.

Please check if any of the following categories are applicable:

_____ **HANDICAPPED INDIVIDUAL** – Any person who (1) has a physical or mental impairment that substantially limits one or more of his or her major life activities; (2) has a record of such impairment, or (3) is regarded as having such an impairment. A handicap is “substantially limited” if it is likely to cause difficulty in securing, retaining, or advancing in employment.

_____ **VETERAN ELIGIBILITY** – Served in armed forces between August 5, 1964 and May 7, 1975.

_____ **DISABLED VETERAN ELIGIBILITY** – A veteran with a disability, service connected or otherwise.

EEO Log: _____

AUTHORIZATION TO OBTAIN INVESTIGATION REPORTS

I _____, hereby authorize _____
(Name of Applicant) (Company)
to obtain any investigation reports on me in connection with my application for employment
and/or at any time during my employment with _____ if I am
(Company)
hired or if I am a current employee, for employment purposes including, but not limited to,
reassignment, promotion, retention and rehiring.

I have received and read a Notice and Disclosure explaining that such investigation reports may include information concerning my creditworthiness, credit standing, credit capacity, character, general reputation, personal characteristics, and/or mode of living. This information may be obtained from personal interviews with my professional and personal acquaintances.

I understand that _____ and its agents are not responsible for
(Company)
the accuracy or completeness of the information contained in any such reports. I release
_____ and its agents from all liability, claims, and lawsuits with
(Company)
respect to the information obtained from any or all of the sources used by
_____.
(Company)

I understand that this authorization is not an offer for employment by
_____ and that any false or misleading information I have provided
(Company)
to _____ may result in a refusal to hire, promote, reassign, or
(Company)
continued employment.

I also understand that this authorization is a continuing authorization and will remain valid until such time as I inform _____, in writing, that I wish
(Company)
to revoke this authorization.

Date: _____ By: _____
(Signature of Applicant)
By: _____
(Name of Applicant)

[] By checking this box, I have indicated that I would like a copy of a credit report if one is obtained by _____.
(Company)

**NOTIFICATION OF REQUEST FOR INVESTIGATIVE CONSUMER REPORT
(UNDER FAIR CREDIT REPORTING ACT)**

(Date)

(Name of Applicant)

(Street Address)

(City, State, Zip)

Dear _____:
(Name)

This letter serves to notify you that _____ has ordered an investigative consumer report about you. This report may include information about your character, general reputation, personal characteristics, and mode of living. Such information may be obtained through personal interviews with your professional and personal acquaintances.
(Company)

You have the right to request a complete disclosure of the nature and scope of the investigation that was requested. You must make this request in writing and within a reasonable period of time after receipt of this Notice and Disclosure.

If you make this written request, we are required to and will provide a complete disclosure of the nature and scope of the investigation to you in a written statement. You will receive this written statement no later than five (5) days from the date we receive your request for disclosure or the date we first requested the report, whichever is later in time.

Enclosed is a copy of A Summary of Your Rights Under the *Fair Credit Reporting Act*.

Date: _____

(Signature & Title of Company Representative)

(Typed Name & Title of Company Representative)

A Summary of Your Rights Under the Fair Credit Reporting Act

The federal Fair Credit Reporting Act (FCRA) promotes the accuracy, fairness, and privacy of information in the files of consumer reporting agencies. There are many types of consumer reporting agencies, including credit bureaus and specialty agencies (such as agencies that sell information about check writing histories, medical records, and rental history records). Here is a summary of your major rights under the FCRA. **For more information, including information about additional rights, go to www.ftc.gov/credit or write to: Consumer Response Center, Room 130-A, Federal Trade Commission, 600 Pennsylvania Ave. N.W., Washington, D.C. 20580.**

- **You must be told if information in your file has been used against you.** Anyone who uses a credit report or another type of consumer report to deny your application for credit, insurance, or employment – or to take another adverse action against you – must tell you, and must give you the name, address, and phone number of the agency that provided the information.
- **You have the right to know what is in your file.** You may request and obtain all the information about you in the files of a consumer reporting agency (your “file disclosure”). You will be required to provide proper identification, which may include your Social Security number. In many cases, the disclosure will be free. You are entitled to a free file disclosure if:
 - a person has taken adverse action against you because of information in your credit report;
 - you are the victim of identify theft and place a fraud alert in your file;
 - your file contains inaccurate information as a result of fraud;
 - you are on public assistance;
 - you are unemployed but expect to apply for employment within 60 days. In addition, by September 2005 all consumers will be entitled to one free disclosure every 12 months upon request from each nationwide credit bureau and from nationwide specialty consumer reporting agencies. See www.ftc.gov/credit for additional information.
- **You have the right to ask for a credit score.** Credit scores are numerical summaries of your credit-worthiness based on information from credit bureaus. You may request a credit score from consumer reporting agencies that create scores or distribute scores used in residential real property loans, but you will have to pay for it. In some mortgage transactions, you will receive credit score information for free from the mortgage lender.
- **You have the right to dispute incomplete or inaccurate information.** If you identify information in your file that is incomplete or inaccurate, and report it to the consumer reporting agency, the agency must investigate unless your dispute is frivolous. See www.ftc.gov/credit for an explanation of dispute procedures.
- **Consumer reporting agencies must correct or delete inaccurate, incomplete, or unverifiable information.** Inaccurate, incomplete or unverifiable information must be removed or corrected, usually within 30 days. However, a consumer reporting agency may continue to report information it has verified as accurate.
- **Consumer reporting agencies may not report outdated negative information.** In most cases, a consumer reporting agency may not report negative information that is more than seven years old, or bankruptcies that are more than 10 years old.

- **Access to your file is limited.** A consumer reporting agency may provide information about you only to people with a valid need -- usually to consider an application with a creditor, insurer, employer, landlord, or other business. The FCRA specifies those with a valid need for access.
- **You must give your consent for reports to be provided to employers.** A consumer reporting agency may not give out information about you to your employer, or a potential employer, without your written consent given to the employer. Written consent generally is not required in the trucking industry. For more information, go to www.ftc.gov/credit.
- **You may limit "prescreened" offers of credit and insurance you get based on information in your credit report.** Unsolicited "prescreened" offers for credit and insurance must include a toll-free phone number you can call if you choose to remove your name and address from the lists these offers are based on. You may opt-out with the nationwide credit bureaus at 1-888-5-OPTOUT (1-888-567-8688).
- **You may seek damages from violators.** If a consumer reporting agency, or, in some cases, a user of consumer reports or a furnisher of information to a consumer reporting agency violates the FCRA, you may be able to sue in state or federal court.
- **Identity theft victims and active duty military personnel have additional rights.** For more information, visit www.ftc.gov/credit.

States may enforce the FCRA, and many states have their own consumer reporting laws. In some cases, you may have more rights under state law. For more information, contact your state or local consumer protection agency or your state Attorney General. Federal enforcers are:

TYPE OF BUSINESS:	CONTACT:
Consumer reporting agencies, creditors and others not listed below	Federal Trade Commission: Consumer Response Center - FCRA Washington, DC 20580 1-877-382-4357
National banks, federal branches/agencies of foreign banks (word "National" or initials "N.A." appear in or after bank's name)	Office of the Comptroller of the Currency Compliance Management, Mail Stop 6-6 Washington, DC 20219 800-613-6743
Federal Reserve System member banks (except national banks, and federal branches/agencies of foreign banks)	Federal Reserve Consumer Help (FRCH) P O Box 1200 Minneapolis, MN 55480 Telephone: 888-851-1920 Website Address: www.federalreserveconsumerhelp.gov Email Address: ConsumerHelp@FederalReserve.gov
Savings associations and federally chartered savings banks (word "Federal" or initials "F.S.B." appear in federal institution's name)	Office of Thrift Supervision Consumer Complaints Washington, DC 20552 800-842-6929
Federal credit unions (words "Federal Credit Union" appear in institution's name)	National Credit Union Administration 1775 Duke Street Alexandria, VA 22314 703-519-4600
State-chartered banks that are not members of the Federal Reserve System	Federal Deposit Insurance Corporation Consumer Response Center, 2345 Grand Avenue, Suite 100 Kansas City, Missouri 64108-2638 1-877-275-3342
Air, surface, or rail common carriers regulated by former Civil Aeronautics Board or Interstate Commerce Commission	Department of Transportation, Office of Financial Management Washington, DC 20590 202-366-1306
Activities subject to the Packers and Stockyards Act, 1921	Department of Agriculture
	Office of Deputy Administrator - GIPSA Washington, DC 20250 202-720-7051



To our policyholders:

California law requires employers to provide a form on which employees may indicate the name of their personal physician or personal chiropractor. The form must be provided to new hires either at the time the employee is hired or by the end of the first pay period.

This form is available from your State Fund representative at no cost to you. Keep a supply on hand. Document personnel records, indicating when this form was provided and when it was returned to you.

PLEASE SEE REVERSE SIDE

After completion by employee, keep original in the employee's personnel file, and provide a copy to your employee.

If I am injured on the job, I wish to be treated by my personal physician or personal chiropractor, who has treated me before and who has my medical or chiropractic treatment records.

Si me lesionara en el trabajo, quisiera que me atienda mi médico personal o mi quiropráctico personal; quien me ha atendido antes y tiene mi expediente médico o expediente quiropráctico.

EMPLOYEE'S INFORMATION:

NAME/NOMBRE: _____

YOUR DOCTOR'S INFORMATION:

DOCTOR: _____

ADDRESS/DIRECCION: _____ PHONE/TEL: _____

CITY/CIUDAD: _____ STATE/ESTADO: _____ ZIP/CODIGO: _____



EMPLOYEE'S SIGNATURE
FIRMA DEL EMPLEADO

DATE
FECHA

(Fold)

DI Office Locations and Mailing Addresses

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



STATE OF CALIFORNIA

LABOR AND WORKFORCE DEVELOPMENT AGENCY

EMPLOYMENT DEVELOPMENT DEPARTMENT

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

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

(Fold)

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

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

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

DI Plans

- **State Plan.** The DI state plan is covered in this brochure.
 - **Voluntary Plan (VP).** A private plan, approved by the Director of the EDD, which may be substituted for the State Plan. Voluntary Plans may be established if the employer and majority of employees agree to do so. VP information and filing a claim may be done through your employer. If you are covered by a VP, the provisions of this brochure may not apply to you. Obtain information about your coverage and file a VP claim through your employer.
 - **Elective Coverage (EC).** Employers and self-employed persons, including general partners, may elect coverage. The method of computing benefits for EC participants is not the same as for mandatory rate payers. The cost of participating, which is set annually, can be obtained from your local EDD Employment Tax Customer Service Office.
- EC claims are filed in the same manner as State Plan claims; however, there are some differences in eligibility requirements from those listed in this pamphlet.
- For additional information or to apply for coverage, contact EDD DI customer service at 1-800-480-3287, EDD employment tax customer service at 1-888-745-3886, or visit our website at www.edd.ca.gov/disability.

How to Claim State Plan Benefits

1. Use **SDI Online** to securely file for benefits or request a paper claim form online.
 - By Internet: www.edd.ca.gov/disability.
 - By phone: **1-800-480-3287**.
 - By mail: EDD, Disability Insurance, PO Box 989777, West Sacramento, CA 95798-9777.
 2. In person by visiting any of the DI offices listed under "DI Office Locations."
 - California state government employees covered by SDI should call **1-866-352-7675**.
2. When filing using SDI Online, complete all required fields. A receipt number will be generated when your claim is submitted. If using a paper *Claim for Disability Insurance (DI) Benefits* (DE 2501) form, complete and sign Part A-Claimant's Statement. Print clearly, and verify your answers are complete and correct as errors delay payment.
 3. Have your physician/practitioner complete the Part B - Physician/Practitioner's Certificate online or use the paper claim form. If filing online, your physician/practitioner will need your receipt number to complete the Part B - Physician/Practitioner's Certificate. Usually a claim cannot begin more than seven days before you were examined by or under the care of a physician/practitioner. Certification may be made by a licensed medical or osteopathic physician and surgeon, nurse practitioner, physician assistant, chiropractor, dentist, podiatrist, optometrist, designated psychologist, or an authorized medical officer of a United States government facility. Certification may also be made by a licensed nurse-midwife or licensed midwife for disabilities related to normal pregnancy or childbirth.
 4. File online or submit your paper claim form within 49 days from the date your disability begins. If your claim is late, you may lose benefits unless your explanation of the delay is accepted as reasonable.



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How Benefits Are Paid

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

- The first seven days of your DI claim are a non-payable waiting period. If a claim is filed for the same or related cause or condition within 60 days of the initial claim, it will be processed as a continuation of the initial claim for which a waiting period was already served. There will not be a new waiting period in such cases.

Benefits are paid as quickly as possible after all information to determine eligibility is received. If you meet all eligibility requirements, benefits will be authorized. If you are eligible for further benefits, you will be authorized for additional benefits electronically or sent a *Claim For Continued Disability Benefits* (DE 2500A) certification form for you to complete for the next benefit period. Usually these benefit periods are for two-week intervals. However, DI pays benefits based on daily eligibility within a seven-day calendar week. Partial weeks are paid at a daily rate. This rate is one-seventh of your weekly benefit amount. Please allow 10 days from the date you mail or electronically submit a certification for receipt of payment.

How Your Benefit Rate is Determined

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

If your claim begins in:

- **January, February, or March, your base period is the 12 months ending last September 30.** (Example: A claim beginning February 14, 2017, uses a base period of October 1, 2015, through September 30, 2016.)
- **April, May, or June, your base period is the 12 months ending last December 31.** (Example: A claim beginning June 20, 2017, uses a base period of January 1, 2016, through December 31, 2016.)
- **July, August, or September, your base period is the 12 months ending last March 31.** (Example: A claim beginning September 27, 2017, uses a base period of April 1, 2016, through March 31, 2017.)
- **October, November, or December, your base period is the 12 months ending last June 30.** (Example: A claim beginning November 2, 2017, uses a base period of July 1, 2016, through June 30, 2017.)

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

- You may be entitled to substitute wages paid in prior quarters to either validate your claim or increase your benefit amount, if during your base period you:
- Were in the military service.
 - Received workers' compensation benefits.
 - Did not work because of a labor dispute.

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

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

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

Additionally, benefits are payable only for a limited period to a resident in an alcoholic recovery home or drug-free residential facility that is both licensed and certified by the state in which the facility is located. However, disabilities related to or caused by acute or chronic alcoholism or drug abuse, being medically treated, do not have this limitation.

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

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

You May Not be Eligible for Benefits

- If you are receiving Unemployment Insurance or PFL benefits.
 - If you are not working or looking for work at the time your disability begins.
 - If you are in custody due to conviction of a crime.
 - If your full wages are paid.
 - If you are receiving workers' compensation at a weekly rate equal to or greater than the DI rate. If workers' compensation benefits are paid at a lower rate than your DI rate, you may be paid the difference.
 - For the amount of time a claim is late (without good cause).
 - If you make a false statement or fail to report a material fact. (A 30 percent penalty may be assessed if benefits are overpaid because you willfully withheld a material fact or made a false statement.)
 - If you fail to attend an independent medical examination when requested. (Fees for such examinations are paid by the EDD.)
- The California Unemployment Insurance Code provides for penalties consisting of fines, imprisonment, and loss of benefit rights for fraud against the SDI program.

Your Rights. You are entitled to:

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

Your Obligations. Your responsibilities:

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

Contact DI

- By email at <https://askedd.edd.ca.gov>.

- By phone at:
 - English 1-800-480-3287
 - Spanish 1-866-658-8846

- By **U.S. mail** addressed to PO Box 13140, Sacramento, CA 95813-3140. If you do not have a current claim, you may write to any DI office. Note: Do not mail claim forms to this PO Box.

- By **TTY** (teletypewriter for deaf, hearing-impaired, and speech-impaired persons only) at 1-800-563-2441.

- **In person** by visiting any of the DI offices listed under "DI Office Locations."

Other Programs

If you are injured on the job or become ill as a result of your occupation, notify your employer. If you are able and available to work but unemployed, contact the Unemployment Insurance program of the EDD through the website at www.edd.ca.gov/unemployment, or by phone at 1-800-300-5616 (TTY 1-800-815-9387).

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

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

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

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

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

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

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

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Lista de las Oficinas del Seguro de Discapacidad (DI)

Chico 645 Salem Street
(escriba a: PO Box 8190, Chico, CA 95927-8190)

Chino Hills ... 15315 Fairfield Ranch Road, Ste. 100
(escriba a: PO Box 60006, City of Industry, CA 91716-0006)

Fresno 2550 Mariposa Mall, Rm. 1080A
(escriba a: PO Box 32, Fresno, CA 93707-0032)

Long Beach ... 4300 Long Beach Blvd., Ste. 600
(escriba a: PO Box 469, Long Beach, CA 90801-0469)

Los Angeles 888 S. Figueroa Street, Ste. 200
(escriba a: PO Box 513096, Los Angeles, CA 90051-1096)

Oakland 7677 Oakport Street, Ste. 325
(escriba a: PO Box 1857, Oakland, CA 94606-1857)

Riverside 1190 Palmyrita Avenue, Ste. 100
(escriba a: PO Box 59903, Riverside, CA 92517-9903)

Sacramento 5009 Broadway
(PO Box 13140, Sacramento, CA 95813-3140)

San Bernardino 371 West 3rd Street
(escriba a: PO Box 781, San Bernardino, CA 92402-0781)

San Diego ... 9246 Lightwave Avenue, Bldg. A, Ste. 300
(escriba a: PO Box 120831, San Diego, CA 92112-0831)

San Francisco 745 Franklin Street, Rm. 300
(escriba a: PO Box 193534, San Francisco, CA 94119-3534)

San Jose 297 West Hedding Street
(escriba a: PO Box 637, San Jose, CA 95106-0637)

Santa Ana ... 605 West Santa Ana Blvd., Bldg. 28, Rm. 735
(escriba a: PO Box 1466, Santa Ana, CA 92702-1466)

Santa Barbara 128 East Ortega Street
(escriba a: PO Box 1529, Santa Barbara, CA 93102-1529)

Santa Rosa 606 Healdsburg Avenue
(escriba a: PO Box 700, Santa Rosa, CA 95402-0700)

Stockton 3127 Transworld Dr., Ste. 150
(escriba a: PO Box 201006, Stockton, CA 95201-9006)

Los Empleados del Gobierno Estatal de California
(escriban a: PO Box 2168, Stockton, CA 95201-2168)

Van Nuys 15400 Sherman Way, Rm. 500
(escriba a: PO Box 10402, Van Nuys, CA 91410-0402)



INFORMACIÓN Y REQUISITOS DEL SEGURO DE DISCAPACIDAD (DI)



ESTADO DE CALIFORNIA

AGENCIA DEL TRABAJO Y DESARROLLO DE LA FUERZA LABORAL

DEPARTAMENTO DEL DESARROLLO DEL EMPLEO (EDD)

Este folleto solamente proporciona información general, y no tiene ni fuerza ni efecto de ley, reglamento o regulación.

El Departamento del Desarrollo del Empleo (EDD) ofrece igualdad de oportunidad al empleo, acceso a sus programas y servicios. Servicios de asistencia para las personas con discapacidades están disponibles cuando se soliciten. Para pedir servicios, asistencia y/o formatos alternos, comuníquese al **1-800-490-8879** o por TTY (telelipo) al 711.

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Una discapacidad es una enfermedad o lesión, ya sea física o mental, que le impide al trabajador desempeñar su trabajo acostumbrado. Un caso de discapacidad puede incluir una cirugía electiva, un embarazo, un parto o condiciones médicas relacionadas con el parto.

Seguro de Discapacidad (DI)
El Seguro de Discapacidad (DI), por sus iniciales en inglés) forma parte del programa del Seguro Estatal de Discapacidad (SDI), por sus iniciales en inglés), el cual es manejado por el estado de California. Este seguro ha sido diseñado para reemplazar parcialmente los salarios/sueldos que un individuo puede perder debido a una discapacidad **no** relacionada con el empleo.

Atención: Consulte la sección "Otros Programas", en este folleto, para obtener información sobre los programas y recursos disponibles para casos de discapacidad que **si** están relacionados con el empleo.

Los fondos del Seguro Estatal de Discapacidad (SDI) se componen de contribuciones que son directamente pagadas por los trabajadores de California, quienes son cubiertos por este seguro. Los costos del seguro pueden variar de un año a otro. Para estar al tanto sobre los costos actuales, visite la página de Internet del Seguro Estatal de Discapacidad (SDI) en www.edd.ca.gov/disability, o comuníquese con la oficina del Seguro de Discapacidad (DI), llamando al **1-866-658-8846**, o con el Centro de Asistencia al Contribuyente del Departamento del Desarrollo del Empleo (EDD), por sus iniciales en inglés), al **1-888-745-3886**.

Cómo Solicitar Pagos de Beneficios del Seguro de Discapacidad (DI)

1. A continuación se encuentran los diferentes métodos para solicitar pagos de beneficios del Seguro de Discapacidad (DI):
 - Por Internet en SDI Online, visite www.edd.ca.gov/disability.
 - Por teléfono, llamando al **1-866-658-8846**.
 - Por correo postal, **Disability Insurance (DI), PO Box 989777, West Sacramento, CA 95798-9777**. Para ordenar el formulario en papel de la *Solicitud de Beneficios del Seguro de Discapacidad (DI)* (DE 2501), visite la página *Online Forms and Publications*, (solamente disponible en inglés).
 - En persona, visite cualquiera de las oficinas del Seguro de Discapacidad (DI) indicadas en la "Lista de las Oficinas del Seguro de Discapacidad (DI)" en este folleto.
 - Los empleados del gobierno estatal de California cubiertos por el Seguro Estatal de Discapacidad (SDI), deben llamar al **1-866-352-7675**.

2. Si utiliza SDI Online para solicitar pagos de beneficios, asegúrese de contestar todas las preguntas y de completar todos los espacios requeridos de la *Solicitud de Beneficios del Seguro de Discapacidad (DI)*. Cuando presente la solicitud se le proporcionará un número de recibo.

Si usted decide completar el formulario en papel de la *Solicitud de Beneficios del Seguro de Discapacidad (DI)* (DE 2501), asegúrese de contestar todas las preguntas, de completar todas las secciones y de firmar el documento. Al llenar el formulario, escriba claramente en letra de molde y verifique que sus respuestas sean completas y correctas, ya que los errores pueden demorar la entrega de los pagos de beneficios que le pueden corresponder.

3. Asegúrese que su doctor médico/profesional (médico) complete el Certificado de Doctor Médico/Profesional (Médico) (*Physician/Practitioner Certification*, en inglés) en SDI Online o complete la parte B del formulario en papel de la *Solicitud de Beneficios del Seguro de Discapacidad (DI)* (DE 2501). Si el solicitante presenta la solicitud en SDI Online, su doctor médico/profesional (médico) va a necesitar el número de recibo para poder completar la sección que le corresponde.

Por lo general, después de ser presentada la *Solicitud de Beneficios del Seguro de Discapacidad (DI)*, la solicitud no

puede entrar en vigencia siete días antes de que el solicitante haya sido examinado o haya estado bajo el cuidado de un doctor médico/profesional (médico) que certifique su discapacidad. La certificación puede ser hecha por un médico o un médico osteópata y cirujano con licencia, enfermero(a) practicante, un médico quiropráctico, un dentista, un podiatra, un optometrista, un psicólogo aprobado, o por un oficial médico autorizado de una instalación del gobierno de los Estados Unidos. La certificación también puede ser hecha por una enfermera partera con licencia o una partera con licencia para discapacidades relacionadas al embarazo normal o de parto.

4. Asegúrese de presentar la *Solicitud de Beneficios del Seguro de Discapacidad (DI)* en SDI Online o por correo postal al Departamento del Desarrollo del Empleo (EDD) dentro de un plazo de 49 días a partir del primer día en que usted quedó discapacitado. Si usted presenta la solicitud tarde, es posible que pierda su elegibilidad para recibir pagos de beneficios del Seguro de Desempleo (DI), a menos que proporcione una razón que justifique por qué es que se tardó en hacerlo.

Cómo Se Pagan los Beneficios del Seguro de Discapacidad (DI)

Los pagos de beneficios del Seguro de Discapacidad (DI) se hacen a través de la Tarjeta de Débito EDD. La Tarjeta de Débito EDD funciona como otras tarjetas de débito con acceso a fondos bancarios las 24 horas del día, los siete días de la semana. La tarjeta de débito se puede usar donde quiera que se acepten las tarjetas de débito Visa. Cuando el Departamento (EDD) reciba su *Solicitud de Beneficios del Seguro de Discapacidad (DI)*, es posible que un representante del Departamento (EDD) se comunice con usted a través de SDI Online, por correo postal, o por teléfono, para pedirle información adicional si es necesario. La mayoría de las solicitudes para beneficios del Seguro de Discapacidad (DI) completadas correctamente y firmadas se tramitan dentro de 14 días.

Una vez que una *Solicitud de Beneficios del Seguro de Discapacidad (DI)* sea tramitada por el Departamento (EDD), se debe cumplir una semana de espera (los primeros siete días a partir de la fecha inicial de la solicitud), por la cual no se le hacen pagos de beneficios al solicitante. Después de establecerse la elegibilidad del solicitante, el Departamento (EDD) le hará el primer pago de beneficios al solicitante a través de la Tarjeta de Débito EDD lo más pronto posible.

Si el solicitante llega a presentar otra *Solicitud de Beneficios del Seguro de Discapacidad (DI)* dentro de 60 días a partir de la fecha de haber presentado la solicitud inicial para beneficios del Seguro de Discapacidad (DI), por la misma causa o condición médica o algo relacionado a esa causa, esa solicitud será tramitada como una continuación de la solicitud inicial y el solicitante no tendrá que volver a cumplir con la semana de espera.

Si el solicitante es elegible para recibir pagos de beneficios adicionales, se le enviará el formulario en papel de la *Solicitud de Beneficios Continuos de Discapacidad (DI)* (DE 2500AS) para completar y presentar. Si el solicitante falla en completar cualquier formulario requerido por el Departamento (EDD), se arriesga a no recibir pagos de beneficios. El Seguro de Discapacidad (DI) hace pagos de beneficios con base a la elegibilidad diaria del solicitante en cada semana de calendario de siete días por la cual se esté solicitando pagos de beneficios. Las semanas parciales se pagan basado en la cantidad diaria (una séptima parte) de beneficios que posiblemente se le puedan pagar al solicitante por cada día que sea elegible para recibir pagos de beneficios. Por favor, permita 10 días, a partir de la fecha en la que presente al Departamento (EDD) el formulario en papel de la *Solicitud de Beneficios Continuos de Discapacidad (DI)* (DE 2500AS) o presente la *Solicitud de Beneficios Continuos de Discapacidad (DI)* en SDI Online, para recibir el pago de beneficios correspondiente, si es que es elegible.

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Cómo Se Determina la Cantidad de Pago de Beneficios Semanal

La cantidad de pago de beneficios semanal se basa en la cantidad total de los salarios/sueldos que ganó el solicitante durante el **período reglamentario** de 12 meses correspondiente a la solicitud. El período reglamentario se determina con base a la fecha en que primero se estableció la *solicitud para Beneficios del Seguro de Discapacidad (DI)*. El solicitante debe considerar cuándo presentar la Solicitud de Beneficios del Seguro de Discapacidad (DI), ya que esto puede afectar la cantidad de pagos de beneficios que puede recibir el solicitante semanalmente. La cantidad máxima de beneficios que puede recibir en total y el período de elegibilidad que por el que puede recibir pagos de beneficios.

Solamente, los salarios/sueldos que ganó el solicitante durante el período reglamentario que fueron sujetos a impuestos del Seguro Estatal de Discapacidad (SDI), se pueden usar para calcular la cantidad máxima de beneficios que el solicitante puede recibir.

Para ser elegible para recibir pagos de beneficios, el solicitante tiene que haber ganado por lo menos \$3,000 durante un trimestre del período reglamentario. El mes en el cual entre en vigencia la solicitud para beneficios del Seguro de Discapacidad (DI) determina cuál de los cuatro trimestres consecutivos indicados a continuación se usará para determinar la cantidad máxima de beneficios que el solicitante puede recibir en pagos de beneficios semanalmente.

Si su solicitud para beneficios del Seguro de Discapacidad (DI) fue establecida en:

- Enero, febrero, o marzo, el período reglamentario de 12 meses que le corresponde a la solicitud terminó el 30 de septiembre del año anterior.** Por ejemplo: Una solicitud para beneficios del Seguro de Discapacidad (DI) establecida el 14 de febrero de 2016, le corresponde el período reglamentario que empezó el 1o de octubre de 2014 y terminó el 30 de septiembre de 2015.
 - Abril, mayo, o junio, el período reglamentario de 12 meses que le corresponde a la solicitud terminó el 31 de diciembre del año anterior.** Por ejemplo: Una solicitud para beneficios del Seguro de Discapacidad (DI) establecida el 20 de junio de 2016, le corresponde el período reglamentario que empezó el 1o de enero de 2015 y terminó el 31 de diciembre de 2015.
 - Julio, agosto, o septiembre, el período reglamentario de 12 meses que le corresponde a la solicitud terminó el 31 de marzo del año anterior.** Por ejemplo: Una solicitud para beneficios del Seguro de Discapacidad (DI) establecida el 27 de septiembre de 2016, le corresponde el período reglamentario que empezó el 1o de abril de 2015 y terminó el 31 de marzo de 2016.
 - Octubre, noviembre, o diciembre, el período reglamentario de 12 meses que le corresponde a la solicitud terminó el 30 de junio del año anterior.** Por ejemplo: Una solicitud para beneficios del Seguro de Discapacidad (DI) establecida el 2 de noviembre de 2016, le corresponde el período reglamentario que empezó el 1o de julio de 2015 y terminó el 30 de junio de 2016.
- Excepciones**
- Si el Departamento (EDD) determina que su solicitud para beneficios del Seguro de Discapacidad (DI) no es válida por que no cumple con el requisito de la cantidad mínima de salarios/sueldos que debe de haber ganado usted, el solicitante, durante el trimestre del período reglamentario correspondiente a su solicitud, pero continúa desempleado y en busca de un empleo por más de 60 días durante cualquier otro trimestre del período reglamentario, es posible que usted pueda sustituir los salarios/sueldos ganados en un trimestre anterior por los salarios/sueldos ganados en el trimestre del período reglamentario correspondiente a su solicitud.

Es posible que también se puedan sustituir los salarios/sueldos ganados en otros trimestres anteriores, ya sea para hacer válida su solicitud para beneficios del Seguro de Discapacidad (DI) o

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para aumentar la cantidad máxima de beneficios que el solicitante pueda recibir, si durante el período reglamentario correspondiente a su solicitud usted:

- Estaba prestando servicio militar; o
- Recibió pagos de beneficios de compensación para trabajadores (*workers' compensation*); o
- No trabajó debido a una disputa laboral.

Si su solicitud es afectada por cualquiera de las circunstancias indicadas arriba, entonces escriba una carta y preséntela junto con su *Solicitud de Beneficios del Seguro de Discapacidad (DI)* (DE 2501) al Departamento (EDD). Para las *Solicitudes de Beneficios del Seguro de Discapacidad (DI)* presentadas en SDI Online, los solicitantes deben ingresar a su cuenta de SDI Online y enviar un mensaje al Departamento (EDD) proporcionando la información apropiada y necesaria sobre su situación.

Si Usted Está Discapacitado y Continúa Recibiendo Pagos de Salarios/Sueldos Por Parte de Su Empleador

Si su empleador continúa pagándole salarios/sueldos mientras está usted discapacitado, esto puede afectar su elegibilidad y la cantidad de pago de beneficios semanales que puede recibir del Seguro de Discapacidad (DI). La cantidad del pago total de beneficios del Seguro de Discapacidad (DI) en combinación con los salarios/salarios pagados por un empleador no pueden ser más que la cantidad del salario/sueldo semanal normalmente ganado por el solicitante. La elegibilidad, la cantidad de pago de beneficios semanal y la cantidad máxima de beneficios que el solicitante puede recibir del Seguro de Discapacidad (DI), no son afectadas por un pago de vacaciones que reciba el solicitante.

Cantidad Máxima de Beneficios

El solicitante puede recibir del Seguro de Discapacidad (DI) su cantidad máxima de beneficios en 52 pagos (un pago por semana), mientras la cantidad máxima no sea más que la cantidad total de los salarios/sueldos que el solicitante ganó durante el período reglamentario correspondiente a la solicitud. La excepción son aquellos empleadores y personas que trabajan por su cuenta propia que eligen el plan de Cobertura Electiva del Seguro de Discapacidad (DIEC, por sus iniciales en inglés). La cantidad máxima de beneficios que este tipo de solicitante puede recibir del Seguro de Discapacidad (DI) son 39 pagos (un pago por semana).

Recuperación del Abuso de las Drogas o el Alcohol

Los pagos de beneficios del Seguro de Discapacidad (DI) se pueden pagar solamente por un período limitado a aquellas personas internadas en un establecimiento para la recuperación del alcoholismo o de tratamiento del abuso de las drogas. Se requiere que el establecimiento tenga una licencia y un certificado del estado donde el solicitante se encuentre ubicado. Sin embargo, las discapacidades relacionadas o causadas por el alcoholismo o el abuso de drogas, que sean graves y estén bajo tratamiento médico, no tienen esta limitación.

Embarazo

Como con cualquier condición médica, el primer día en que empieza el período de discapacidad es en el mismo día en que la elegibilidad no pueda realizar su trabajo normal o acostumbrado. La elegibilidad de la solicitante para recibir pagos de beneficios del Seguro de Discapacidad (DI) se basa en la duración del período de tiempo que el doctor médico/profesional (médico) certifique que la solicitante no puede realizar su trabajo normal o acostumbrado. No es necesario que la solicitante presente una *Solicitud de Beneficios del Seguro de Discapacidad (DI)* en relación a un embarazo, hasta la fecha en que su doctor médico/profesional (médico) determine y la certifique como discapacitada.

Atención: Para obtener información sobre el Permiso Familiar Pagado (PFL), consulte la sección “Otros Programas” en este folleto.

Situaciones en las Que el Solicitante Posiblemente No Sea Elegible para Recibir Pagos de Beneficios del Seguro de Discapacidad (DI)

No todo el solicitante con una discapacidad es elegible para recibir pagos de beneficios del Seguro de Discapacidad (DI), por las siguientes razones:

(Fold)

cualquier formulario o no está seguro de cómo contestarla. Vea la siguiente sección para obtener la información de contacto del Departamento (EDD).

- Incluir su nombre y su número de Seguro Social o Número de Empleo del Solicitante (ECN, por sus iniciales en inglés) en todas las cartas, formularios u otra documentación que presente al Departamento (EDD).

Comuníquese con el Seguro de Discapacidad (DI):

- Por correo electrónico en www.ask.edd.ca.gov.
- Por teléfono, llamando al 1-866-658-8846.
- Por correo postal, escriba al **PO Box 13140, Sacramento, CA 95813-3140**.

Atención: Si usted actualmente no tiene una solicitud para beneficios establecida, puede escribir a cualquiera de las oficinas del Seguro de Discapacidad (DI). No envíe ningún formulario a esta dirección postal.

- Por TTY (teletipo), marque al **1-800-563-2441**.
- En **persona**, visite cualquiera de las oficinas del Seguro de Discapacidad (DI) indicadas en la “Lista de Oficinas del Seguro de Discapacidad (DI)”, la cual se encuentra en este folleto.

Otros Tipos de Planes de Seguros de Discapacidad para Trabajadores

- Plan Voluntario. (Seguro Privado)

Un plan voluntario, es un seguro privado que es obtenido por el empleador y aprobado por el Departamento (EDD). La cobertura de un plan voluntario puede sustituir la cobertura que ofrece el Seguro Estatal de Discapacidad (SDI), siempre y cuando el plan voluntario ofrezca una cobertura similar a la del Seguro Estatal de Discapacidad (SDI), proporcione por lo menos un beneficio adicional mejor que el que ofrece el Seguro Estatal de Discapacidad (SDI), y que el costo del plan voluntario para el empleado, no exceda el costo del Seguro Estatal de Discapacidad (SDI). Los empleadores y grupos de empleados pueden obtener cobertura de un plan voluntario con el consentimiento del empleador y por un voto mayoritario de los empleados. Cualquier empleado puede elegir tener la cobertura del Seguro Estatal de Discapacidad (SDI), aunque un plan voluntario esté disponible en su empleo.

- Cobertura Electiva del Seguro de Discapacidad (DIEC).** Los empleadores y las personas que trabajan por su cuenta propia, incluyendo los socios generales de una compañía o empresa, pueden tener la Cobertura Electiva del Seguro de Discapacidad (DIEC). El método que se utiliza para calcular el costo del seguro no es el mismo que se utiliza para calcular el costo del Seguro de Discapacidad (DI) regular. El costo, fijado anualmente, se puede obtener visitando la oficina local de Atención al Cliente de la Sección de Impuestos Sobre el Empleo del Departamento del Desarrollo del Empleo (EDD), o llamando al **1-888-745-3886**.

La solicitud para beneficios para la Cobertura Electiva del Seguro de Discapacidad (DIEC), se establece del mismo modo que la solicitud para beneficios del Seguro de Discapacidad (DI); sin embargo existen algunas diferencias en los requisitos de elegibilidad para obtener pagos de beneficios del plan de Cobertura Electiva del Seguro de Discapacidad (DIEC).

- Para Obtener Más Información o Cobertura Comuníquese con el Departamento (EDD) a la oficina del Seguro Estatal de Discapacidad (SDI), llamando al **1-866-658-8846**, o con el Centro de Asistencia al Contribuyente al Departamento (EDD), llamando al **1-888-745-3886**, o visite la página de Internet del Seguro Estatal de Discapacidad (SDI) en www.edd.ca.gov/disability.

Otros Programas de Ayuda

Compensación para Trabajadores (*Workers' Compensation*) Si usted se lesiona en el trabajo o se enferma como resultado de su empleo, notifíqueseo a su empleador para iniciar el proceso para solicitar pagos de beneficios de compensación para trabajadores (*workers' compensation*).

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Seguro de Desempleo (UI)

Si usted está desempleado, pero está en buena condición física y disponible para aceptar un empleo, comuníquese con la oficina del Seguro de Desempleo (UI). Para obtener más información, visite la página de Internet del Seguro de Desempleo (UI) en www.edd.ca.gov/unemployment, o llame por teléfono al **1-800-300-5616**, o comuníquese por TTY (teletipo) al **1-800-815-9387**.

Centro de Empleo de América en California (AICC) Si usted necesita ayuda para encontrar un empleo, entrenamiento laboral, u otros servicios para ayudarlo a regresar a trabajar, visite su Centro de Empleo de América en California (AICC, por sus iniciales en inglés) más cercano. Para localizar un centro de empleo, visite www.servicelocator.org (sitio por Internet solamente disponible en inglés).

Seguro Social:

Si usted se encuentra discapacitado permanentemente o a largo plazo (por más de un año), debe comunicarse con la oficina de la Administración del Seguro Social, para obtener información con respecto al programa y su derecho a recibir pagos de beneficios. Comuníquese con la Oficina de la Administración del Seguro Social al **1-800-772-1213** o por TTY (teletipo) al **1-800-325-0778**, o visite su sitio de Internet en www.ssa.gov.

Permiso Familiar Pagado (PFL)

Los trabajadores de California que tienen que ausentarse de su empleo para cuidar un miembro de su familia que se encuentra gravemente enfermo o para establecer lazos afectivos con un nuevo bebé o un niño nuevo adoptado permanentemente o colocado bajo crianza temporal (*roster care*), posiblemente pueden ser elegibles para recibir pagos de beneficios del Permiso Familiar Pagado (PFL, por sus iniciales en inglés). Para obtener más información, visite la página del Seguro Estatal de Discapacidad (SDI) por Internet en www.edd.ca.gov/disability, o comuníquese por teléfono al **1-877-238-4373**, o por TTY (teletipo) al **711**.

Atención: A las nuevas madres, después de dar a luz y se les haya hecho su último pago de beneficios del Seguro de Discapacidad (DI), se les enviará el formulario en papel de la *Solicitud de Beneficios del Permiso Familiar Pagado (DE 2501P)* para que lo completen y presenten para solicitar pagos de beneficios del Permiso Familiar Pagado (PFL) para establecer lazos afectivos con su nuevo bebé. También se puede presentar esta solicitud electrónicamente a través de SDI Online en www.edd.ca.gov/disability.

Víctimas de un Crimen Si usted es una víctima de un crimen y como resultado ha sido herido, es posible que usted sea elegible para recibir asistencia para pagar ciertos costos personales que podrían resultar en relación a tal situación. Para obtener más información comuníquese con el programa de *Compensación para Víctimas de California*, llamando al **1-800-777-9229** o por TTY (teletipo) al **1-800-735-2929**. También puede ponerse en contacto con el Centro de Asistencia para Víctimas o Testigos (*Victim/Witness Assistance Center*) de su condado de residencia.

Pensión Alimenticia (*Spousal Support*)

Si su caso de discapacidad le afecta con cumplir con su obligación de pensión alimenticia, comuníquese con la oficina del fiscal del distrito que le envió la orden de la corte judicial para ver que puede hacer.

Manutención de Hijos

Si su caso de discapacidad le afecta con cumplir con su obligación de manutención de hijos, comuníquese con el Departamento de Servicios de Manutención de Hijos al **1-866-901-3212**, o por TTY (teletipo) al **1-866-399-4096**, para ver que puede hacer.

FOR YOUR BENEFIT

CALIFORNIA'S PROGRAMS FOR THE UNEMPLOYED

**UNEMPLOYMENT INSURANCE
DISABILITY INSURANCE
PAID FAMILY LEAVE
WORKFORCE SERVICES**

For Your Benefit: California's Programs for the Unemployed

This publication provides information about programs offered by the Employment Development Department (EDD) for unemployed Californians. This is for general information only and it is not a legal document.

Additional information is available at www.edd.ca.gov.

Unemployment Insurance (UI)	2
UI benefits provide partial wage replacement to workers who are unemployed through no fault of their own.	
State Disability Insurance (SDI)	13
Disability Insurance (DI) is part of SDI and provides benefits to workers who are unable to work due to a non-work-related illness or injury, pregnancy, or childbirth.	
Paid Family Leave (PFL)	14
PFL is part of SDI and provides partial wage replacement to workers who need time off to care for a seriously ill family member or bond with a new/adopted child.	
Workforce Services	14
The EDD's Workforce Services Branch provides a range of employment services for job seekers.	
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Unemployment Insurance (UI)

UI is paid for by your employer and provides partial income replacement when you are unemployed and meet all eligibility requirements.

Who Should File a UI Claim

To be eligible for UI benefits, you must be out of work, or partially unemployed, due to no fault of your own, be physically able to work, available, and ready to accept work, and actively looking for work.

When to File

You may apply for benefits as soon as you are unemployed or your work hours are reduced. Your claim will begin on the Sunday of the week in which you file your claim.

All claims have a one-week, unpaid waiting period. The waiting period does not begin until you file a claim, certify for benefits, and meet all eligibility requirements.

What You Need to File

To file a claim, you need to provide your:

- Name, (including all names you used while working) and Social Security number.
- Mailing and residence address (if different) and phone number.
- Last employer's complete name, address (mailing and physical location), and phone number.
- Last day worked and the reason you're no longer working (laid off, quit, fired, or left work because of a trade dispute).
- Work history during the 18 months prior to filing your claim, including out-of-state employment. Include all employers' names, dates employed, and wages earned.
- State-issued driver license number or identification card number.
- Citizenship status and if you have the legal right to work in the United States. If you indicate you're registered with the United States Citizenship and Immigration Services (USCIS, formerly INS) and authorized to work in the United States, you'll be asked for the title of your employment authorization document and information from the USCIS document, such as the Alien Registration Number, card number, and/or expiration date.

Note: Your last employer's name and address are very important, regardless of how long you worked for the employer(s). If you worked part-time, provide the number of hours you work each week.

If you served in the military in the last 18 months, you will need to provide information from your DD214 Member copy 4.

If you worked for the federal government during the last 18 months, you will need to provide information from your *Notice to Federal Employees About Unemployment Insurance*, Standard Form 8.

Warning

Making a false statement or withholding information to receive benefits can be a felony. Penalties may include fines, a loss of benefits, and/or criminal prosecution. See additional information on fraud and penalties on page 18.

Employer Notification

Your last employer is notified when you file a UI claim. Although your eligibility is determined by the EDD, employers fund the UI program and are required by law to provide any information that may affect your eligibility to receive benefits.

Types of Claims

The claim you file depends on the type of employer you worked for and the state(s) where you worked.

You will file a:

- Regular California claim if you only worked in California, even if you now live outside of California.
- Federal claim if your employment was in civilian work for the federal government.
- Military claim if you served as a member of the United States Armed Forces.
- Combined wage claim if you earned wages in California and in at least one other state during the last 18 months.
- Interstate claim if you now reside in California and only worked in another state during the last 18 months. File your claim directly with the other state, the District of Columbia, Puerto Rico, or Canada. If you worked in the U.S. Virgin Islands, contact the EDD at 1-800-300-5616.

How to File

You may file a UI claim using one of the following methods:

• Online

Use eApply4UI at www.edd.ca.gov/eapply4ui. This is the fastest way to file a new claim. It is convenient, secure, and available 24 hours a day, seven days a week.

To reopen an existing claim, access your UI Online account, select **Reopen Your Claim**, and answer all of the questions.

- **Phone**

Speak to an EDD representative Monday through Friday between 8 a.m. and 12 noon (Pacific Time), except on state holidays.

Refer to page 19 for a list of UI phone numbers.

- **Fax or Mail**

When accessing eApply4UI, some customers will be instructed to fax or mail their UI application to the EDD. If this occurs, the *Unemployment Insurance Application* (DE 11011) will display.

For faster and more secure processing, fax the completed form to the number listed on the form. If mailing your UI application, use the address on the form and allow additional time for processing.

Beginning Date of Claim

Your claim begins on the Sunday of the week in which you file your claim.

Ending Date of Claim

Your claim ends on the Saturday, 52 weeks after your claim begins. If you exhaust your benefits prior to this date, you cannot file another California claim until the benefit year of the claim ends.

If you worked in another state during the last 18 months, you may be eligible to file a new claim in that state.

Minimum Earnings to Establish a Valid Claim

You must have at least \$1,300 in earnings in one quarter of your base period or at least \$900 in earnings in the highest quarter and 1.25 times your highest quarter earnings in your total base period.

For example: If you have \$900 earnings in your highest quarter, you would also be required to have earned a total of \$1,125 in the base period ($\$900 \times 1.25 = \$1,125$).

How UI Benefits are Calculated

The quarter in which you were paid the highest wages during the base period determines your weekly benefit amount (WBA). The WBA ranges from \$40 to \$450 per week.

The maximum benefit amount is 26 times the weekly benefit amount or one-half of the total base period wages, whichever is less.

Refer to the **Unemployment Insurance Benefit Table** on page 16 to estimate your WBA.

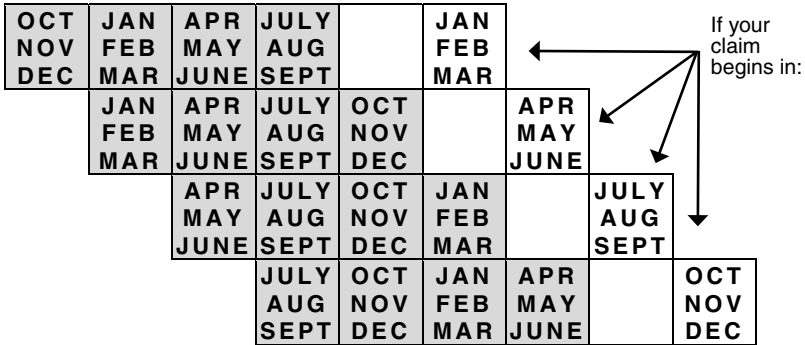
Base Period

There are two types of base periods used to establish a claim: the standard base period and the alternate base period.

Standard Base Period (SBP)

The SBP is the first four of the last five completed calendar quarters prior to the beginning date of the claim.

Refer to the chart below. The shaded area represents a standard base period. The non-shaded area represents the quarter the claim is filed.



Alternate Base Period (ABP)

If you do not have sufficient wages in the standard base period, you may qualify to file a claim using the ABP.

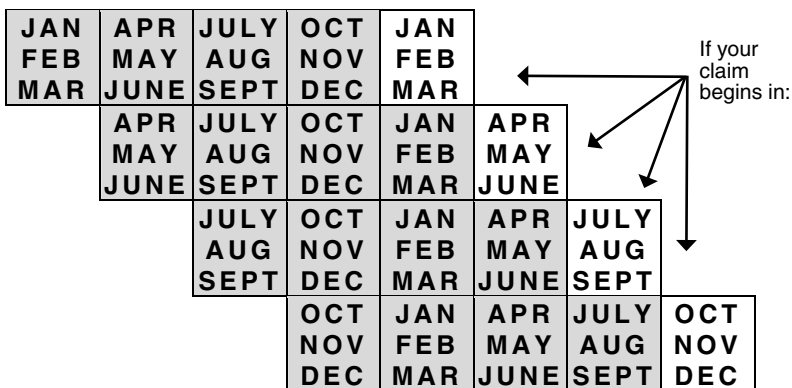
The ABP is the last four completed calendar quarters prior to the beginning date of the claim.

The EDD will automatically file an ABP claim on your behalf if you're not eligible for a SBP claim.

You may be asked to provide additional wage information so the EDD can correctly calculate your benefit amount. If you receive an *Affidavit of Wages* (DE 23A), provide the requested documents and return to the EDD.

Note: The ABP can **only** be used when there are not enough wages earned in the standard base period.

Refer to the chart below. The shaded area represents the ABP. The non-shaded area represents the quarter the claim is filed.



Waiting Period

Unemployment Insurance claims have a mandatory, one week, unpaid waiting period. This waiting period generally takes effect on the first eligible week of a claim and prior to benefits being paid. Do not wait to file your claim because the waiting period cannot be served until a claim has been filed.

How to Certify for Benefits

To serve your waiting period and receive benefit payments, you must meet all eligibility requirements and certify for benefits every two weeks.

There are three ways to certify for benefits:

- **UI OnlineSM:** www.edd.ca.gov/UI_Online
This is the fastest way to certify for benefits and report work and wages. To use UI Online, you must create a secure login through Benefit Programs Online **and** complete a one-time registration for UI Online.

For added convenience, UI Online MobileSM is available from mobile devices.

- **EDD Tele-CertSM:** 1-866-333-4606
Certify over the phone by calling 1-866-333-4606. Select option 2 and follow all instructions. To access EDD Tele-Cert you must create a PIN.
- **Mail:** *Continued Claim form* (DE 4581)
Complete, sign, and mail the form to the EDD.

Note: For faster processing, certify through UI Online or EDD Tele-Cert.

Payments

Payments are issued after you certify for benefits and continue to meet all eligibility requirements for every week you claim benefits.

EDD Debit CardSM

After your first payment is authorized, Bank of America will mail you an EDD Debit Card. The card is valid for three years and used for all Disability Insurance (DI), Paid Family Leave (PFL), and Unemployment Insurance (UI) benefits.

If you have an EDD Debit Card from a previous DI, PFL, or UI claim that is still valid, you will not be mailed a new card until the card has expired.

For more information, visit www.bankofamerica.com/eddcard.

Tax Requirements

UI benefits are subject to federal income tax, but exempt from California state income tax. Each time you certify for benefits, you can choose to withhold the 10 percent federal income tax from your weekly benefit payment. Otherwise, you will be required to pay the tax at the end of the year, when you file your tax return.

Each January, the EDD mails a Form 1099G to individuals who received UI benefits during the previous calendar year. Use the form to report important tax information on your federal tax return. You can access Form 1099G information for up to the past five years and/or request duplicate copies through UI Online or by calling 1-866-401-2849.

Child Support Obligations

Your UI benefits may be reduced if you're required to pay child support payments to a court, District Attorney's office, or other child support enforcement agency.

Report Earnings

You are required to report **all** work, wages, and other income to the EDD during the week they were earned, not when you receive your pay. Failure to properly report your earnings can result in overpayments and penalties.

Types of income to report:

- Piece work
- Idle time pay
- Jury fees
- Commissions
- Witness fees
- Reuse pay
- Holiday pay
- Holding fees
- Residuals
- Award
- Workers' Compensation pension, retirement, annuity
- Vacation pay
- In-lieu-of-notice pay
- Bonuses
- Tips
- Self-employment income
- Strike benefits/picket pay
- Standby pay
- Bereavement
- Back-pay
- Paid sick leave

Note: You must report board, lodging, meals, or any other payment you receive instead of money when you work. If you are unsure about how to report wages, contact the EDD.

Pension or Retirement Pay

UI benefits may be reduced if you are receiving a pension, retirement pay, annuity, or other similar payment based on your previous work.

Social Security benefits are not deductible and do not need to be reported to the EDD.

Part-Time Work

If you work less than full-time, you may still be eligible for partial UI benefits. The first \$25 or 25 percent of your gross total earnings for the week (whichever is greater) will not be counted toward your benefit amount. The amount remaining will be deducted from your weekly benefit amount.

Example 1:

Your weekly benefit amount is \$50. You earn \$30. You must report the \$30; however, the first \$25 is not counted, leaving \$5 to deduct from your weekly benefit amount. You would receive \$45 (\$50 minus \$5) in UI benefits.

Example 2:

Your weekly benefit amount is \$400. You earn \$200. You must report \$200; however, the first 25 percent (\$50) is not counted, leaving \$150 to deduct from your weekly benefit amount. You would receive \$250 (\$400 minus \$150) in UI benefits.

How Your Eligibility is Determined

To be eligible, you must be:

- Out of work due to no fault of your own.
- Physically able to work.
- Ready to accept work.
- Actively looking for work.

If you were laid off, you're considered to be out of work through no fault of your own.

If you quit your last job, were fired, or unemployed due to a strike or lockout, the EDD will schedule a phone interview with you to collect information on the reason you're no longer working. Your UI benefits cannot be paid until your phone interview is complete, you certify for benefits, and the EDD determines your eligibility.

You have the right to request more time to gather information, contact witnesses, or obtain the advice of a representative. If the eligibility issue involves an employer, the EDD may contact the employer.

If you are sent a written request for more information and you respond by mail, the EDD interviewer will use the information provided to determine your eligibility.

If you're denied benefits for any reason throughout your claim, including insufficient wages to establish a claim, a written *Notice of Determination* (DE 1080CZ) will be mailed to you explaining the reason along with your appeal rights.

Important: Your benefits can be delayed or denied if you're not available for the interview or do not submit the required information. The EDD will make a decision of eligibility based on the information available.

Appeals Process

If you're denied UI benefits, you have the legal right to appeal the decision by completing and mailing the *Appeal Form* (DE 1000M). To be considered timely, it must be mailed within 30 calendar days from the mailing date of the *Notice of Determination* (DE 1080CZ). If you miss the 30-day deadline, you may still appeal, but you must show good cause for the delay.

Your appeal will be heard by an independent administrative law judge. Hearings are informal, but all testimony is taken under oath and is subject to cross-examination. The office of appeal will notify you of when and where the hearing will be held.

Before the hearing, you have the right to review all records affecting your appeal. Those records are provided by California Unemployment Insurance Appeals Board (CUIAB). You can request records from the EDD to prepare for your hearing.

At the hearing, you may be represented by yourself, a union official, an attorney, or anyone else you select. You may bring any relevant documentation you may have to support your case.

After the hearing, you are mailed the administrative law judge's decision. If you're not satisfied, you may submit a second level appeal to the CUIAB.

For information on how the UI code is applied, including current case studies, see the Benefit Determination Guide. A copy is available at www.edd.ca.gov/uibdg.

Important: You're required to continue to certify for benefits while your claim is under appeal. If the original decision is reversed, the EDD can quickly issue all back payments to you. **Failure to comply could result in your benefits being denied or delayed.**

Cancelling a Claim

You may cancel a claim if you meet **all** of the following criteria:

- No benefits have been paid.
- You're not disqualified for benefits due to an eligibility issue.
- An overpayment has not been established on the claim.
- You notify the EDD before the 52-week benefit year ends.

Once a claim is canceled, it cannot be re-established with the same beginning date. You must file a new claim, which will have a later beginning date.

Workers Not Covered by Unemployment Insurance

The following groups of workers are not normally covered:

- Elected officials.
- Self-employed, unless participating in elective coverage.
- Students enrolled and regularly attending classes at the school or education institution where employed.
- Members of a Limited Liability Company (LLC) that are treated as a partnership for federal income tax reporting purposes.
- A student's spouse who is working for an educational institution in an employment program provided for the purpose of financially aiding the student.
- Parents employed by their children.
- Husbands and wives employed by each other.
- Certain state-licensed salespersons paid only by commissions.
- Caddies and jockeys.

If you do not know whether you are covered, do not waive your rights. Contact the EDD for more information.

Elective Coverage

Under certain conditions, employers of the individuals whose services are not covered may elect to cover those services. If you're not sure whether you're eligible for these benefits, contact the EDD.

Request a Claim Print Out

You may request a print out of your claim through one of the following methods:

- UI Online at www.edd.ca.gov/UI_Online (account required).
- Ask EDD at www.edd.ca.gov.
- Call the EDD at 1-800-300-5616.

Special Programs

California Training Benefits (CTB)

If you're attending school or training while receiving UI benefits, you may qualify for the CTB program.

If eligible, you can further your education, upgrade your skills, and/or learn a new trade while attending an EDD-approved training or school program to be more competitive in today's labor market.

While in school or training, you'll be exempt from the requirements to be available for work, actively seek work, and accept work. You may also be eligible for additional weeks of benefits. Learn more at www.edd.ca.gov/unemployment/California_Training_Benefits.htm.

Note: The EDD does **not** cover any educational or training-related expenses such as tuition, fees, books, supplies, or transportation. However, there are state, federal, or employer programs that may fund your school or training.

Training Extension (TE)

A TE provides additional benefits to individuals who have been approved for California Training Benefits (CTB), while completing school or training. Only one TE is allowed for each CTB-approved training period.

If interested, you must contact the EDD to inquire about a TE before receiving the 16th week of benefits. For claims that have less than 16 weeks of benefits, you **must** contact the EDD before the claim reaches a zero balance.

Workforce Innovation and Opportunity Act (WIOA)

The WIOA is a federally funded program that provides a range of employment services, education, training, and support services to help job seekers and workers. In California, WIOA services are provided through America's Job Center of CaliforniaSM (AJCC) locations. AJCC locations throughout the state provide in person assistance for no cost. To find an office near you, visit www.americasjobcenter.ca.gov or call 1-877-872-5627.

Disaster Unemployment Assistance (DUA)

The federal DUA program provides financial assistance to individuals whose employment or self-employment has been lost or interrupted as a direct result of a major disaster and who are **not** eligible for regular UI benefits. These benefits are available only when the President of the United States declares a major disaster.

If DUA benefits are available, information will be posted on the EDD website at www.edd.ca.gov.

Trade Adjustment Assistance (TAA)/Re-employment Trade Adjustment Assistance (RTAA)

The TAA program is a federally funded program that provides training and training-related benefits and services to workers who are certified by the U.S. Department of Labor as having lost their jobs, or had their hours and wages reduced, as a result of increased imports from, or a shift in production to, a foreign country.

The RTAA program provides wage subsidies to individuals age 50 or older who return to work paying less than their former trade impacted employment.

Extended Benefits

Extended benefits are available to workers who have exhausted regular unemployment insurance benefits when the unemployment rate equals or exceeds a certain percentage established by state and/or federal law or when the federal government approves special extended benefit legislation.

Railroad Unemployment Benefits

Railroad workers may claim benefits under the U.S. Railroad Unemployment Insurance Act. This program is administered by the U.S. Railroad Retirement Board (RRB).

To file a claim, call the toll-free number at 1-877-772-5772 between 9 a.m. and 3:30 p.m., Monday through Friday to speak to an RRB representative or file online at www.rrb.gov.

Unemployment Insurance Fraud Prevention and Detection

The Employment Development Department (EDD) takes the security of personal and confidential information very seriously. Therefore, all data submitted us is encrypted. Additional safeguards are built in to further protect your personal information from imposter fraud and identity theft.

Imposter fraud occurs when someone intentionally files an UI claim using another person's employment or personal information. The EDD actively investigates cases of imposter fraud and is committed to protecting the identities of legitimate claimants.

If we suspect that there may be identity or imposter issues, you'll receive a written request to validate the information provided to us. We'll also contact your former employer(s) and governmental entities to verify the documents and any information you supply.

For more information, download the *Protect Your Identity and Stop Unemployment Insurance Imposter Fraud* (DE 2360EE) brochure from the EDD website at www.edd.ca.gov/pdf_pub_ctr/de2360ee.pdf.

To report UI fraud, visit <https://askedd.edd.ca.gov> and select **Report Fraud** to submit a Fraud Reporting Form online or call the EDD toll-free fraud hotline at 1-800-229-6297.

Penalties

Making a false statement or withholding information to receive benefits can be a felony. Penalties may include a loss of benefits, a false statement disqualification, and/or criminal prosecution.

A false statement disqualification denies benefits from 2 to 23 weeks. The disqualification stays on your record for three years or until served, whichever comes first. To serve false statement weeks, you must continue to certify for UI benefits, and meet all other eligibility requirements. You will not be paid during this time.

Benefit Audits

The EDD conducts audits by cross-referencing employer information with unemployment (UI) claim information. This allows us to determine if a claimant received benefits after returning to work. Overpayments and penalties collected from these audits ensure the solvency of the UI Trust Fund and help reduce UI taxes.

Social Security Number Verification

The EDD may require you to verify your Social Security number (SSN) as issued to you by the Social Security Administration (SSA).

Your eligibility for benefits may be affected if:

- The SSN provided is under a different name or belongs to another individual.
- The SSN is not valid.
- The SSN was never issued by the SSA.
- The wages in the base period belong to another individual.
- The date of birth at the SSA is different than the date of birth you gave when you filed your claim.

If the EDD requires you to verify your SSN, you may be asked to submit a complete copy of your Social Security Statement. To obtain a copy of your complete Social Security Statement access the SSA website at www.ssa.gov.

A copy of your Social Security card will not satisfy this requirement.

State Disability Insurance (SDI)

SDI is comprised of Disability Insurance and Paid Family Leave. Most workers covered by California UI are also covered by SDI. The program is funded entirely by workers through a payroll tax withheld from their earnings.

Exceptions:

- Employees of local public entities (except workers in district hospitals) are not covered by SDI unless the employer elects such coverage.
- Employees of the state or state-funded institutions of higher education may, through their collective bargaining units, elect to be covered by SDI.
- Self-employed individuals may elect to be covered by SDI.

Disability Insurance (DI)

DI provides short-time, partial wage replacement benefits to workers who are unable to work due to a non-work-related illness or injury, pregnancy, or childbirth.

Your DI claim must be submitted within 49 days from the first day your disability begins. If you miss this deadline, you may lose benefits for the number of days that the claim is late unless you demonstrate good cause for the delay. For faster processing, file your claim using SDI Online.

The first seven days of a DI claim is a non-payable waiting period. Benefits begin with the eighth day of disability. DI is payable for a maximum of 52 weeks.

Exception: If a claim is filed for the same or related cause or condition within 60 days of the initial claim, there will be no new waiting period.

To file a claim or learn more, visit www.edd.ca.gov/disability. EDD staff are available from Monday through Friday between 8 a.m. and 5 p.m. (Pacific Time), except on state holidays.

Refer to page 19 for a list of DI phone numbers.

Paid Family Leave (PFL)

PFL provides partial wage replacement benefits to individuals who need to take time off work to care for a seriously ill child, parent, parent-in-law, grandparent, grandchild, sibling, spouse, or registered domestic partner. Benefits are also available to parents who need time to bond with a new child entering their family either by birth, adoption, or foster care placement. Unlike DI, there is no waiting period.

To file, or learn more visit www.edd.ca.gov/Disability/Paid_Family_Leave.htm.

EDD staff are available from Monday through Friday between 8 a.m. and 5 p.m. (Pacific Time), except on state holidays.

Refer to page 19 for a list of PFL phone numbers.

Workforce Services

The EDD partners with the America's Job Center of CaliforniaSM (AJCC) network and provides no-cost employment services for job seekers and employers throughout California.

Workshops are offered on topics including job search, training, résumé writing, and interview techniques. Employers can use our many services to help recruit qualified candidates for open positions, train current employees, and organize job fairs and workshops.

CalJOBSSM

Job seekers can use CalJOBS to:

- Search for jobs 24 hours a day, 7 days a week. The CalJOBS mobile app is available for download on iTunes and Google Play.
- Create a résumé or upload multiple résumés.
- Explore vocational training, workshops, and other events within their local area.

Note: Registering for a CalJOBS account and posting a résumé is an eligibility requirement for many UI claimants. To register, visit www.caljobs.ca.gov.

Experience Unlimited Program

Professionals from a wide variety of fields can take advantage of EDD-sponsored job clubs. Experience Unlimited provides a place where job seekers can meet with other career professionals to share job leads, provide support, and update their job search skills at no cost. Resources include workshops, résumé evaluations, mock interviews, networking opportunities, and more.

Migrant and Seasonal Farmworkers Program

Assistance is available to farmworkers and food processing workers who may be unfamiliar with the services available through the AJCC network or who have language barriers that might lessen the effectiveness of their job search.

Veterans Services Program

This program assists eligible veterans achieve their employment goals. Services may include an individual employment plan, objective assessment, career counseling, labor market information, job referrals, job search workshops, and job development with potential employers.

Youth Employment Opportunity Program

This special service helps youth, ages 15 through 25, achieve their educational and vocational goals. Services include peer advising, referrals to supportive services, workshops, job referrals and placement assistance, and referrals to training and community outreach efforts.

For more information on the programs and services listed above, visit www.edd.ca.gov/Jobs_and_Training or your nearest AJCC which can be located at www.americasjobcenter.ca.gov.

Unemployment Insurance Benefit Table For New Claims with a Beginning Date of January 2, 2005 or After

Amount of Wages in Highest Quarter	Weekly Benefit Amount	Amount of Wages in Highest Quarter	Weekly Benefit Amount	Amount of Wages in Highest Quarter	Weekly Benefit Amount
\$ 900.00 – 948.99 ...	\$ 40	\$ 2,210.01 – 2,236.00	\$86	\$ 3,406.01 – 3,432.00 ...	\$132
949.00 – 974.99	41	2,236.01 – 2,262.00	87	3,432.01 – 3,458.00	133
975.00 – 1,000.99	42	2,262.01 – 2,288.00	88	3,458.01 – 3,484.00	134
1,001.00 – 1,026.99	43	2,288.01 – 2,314.00	89	3,484.01 – 3,510.00	135
1,027.00 – 1,052.99	44	2,314.01 – 2,340.00	90	3,510.01 – 3,536.00	136
1,053.00 – 1,078.99	45	2,340.01 – 2,366.00	91	3,536.01 – 3,562.00	137
1,079.00 – 1,117.99	46	2,366.01 – 2,392.00	92	3,562.01 – 3,588.00	138
1,118.00 – 1,143.99	47	2,392.01 – 2,418.00	93	3,588.01 – 3,614.00	139
1,144.00 – 1,169.99	48	2,418.01 – 2,444.00	94	3,614.01 – 3,640.00	140
1,170.00 – 1,195.99	49	2,444.01 – 2,470.00	95	3,640.01 – 3,666.00	141
1,196.00 – 1,221.99	50	2,470.01 – 2,496.00	96	3,666.01 – 3,692.00	142
1,222.00 – 1,247.99	51	2,496.01 – 2,522.00	97	3,692.01 – 3,718.00	143
1,248.00 – 1,286.99	52	2,522.01 – 2,548.00	98	3,718.01 – 3,744.00	144
1,287.00 – 1,312.99	53	2,548.01 – 2,574.00	99	3,744.01 – 3,770.00	145
1,313.00 – 1,338.99	54	2,574.01 – 2,600.00	100	3,770.01 – 3,796.00	146
1,339.00 – 1,364.99	55	2,600.01 – 2,626.00	101	3,796.01 – 3,822.00	147
1,365.00 – 1,403.99	56	2,626.01 – 2,652.00	102	3,822.01 – 3,848.00	148
1,404.00 – 1,429.99	57	2,652.01 – 2,678.00	103	3,848.01 – 3,874.00	149
1,430.00 – 1,455.99	58	2,678.01 – 2,704.00	104	3,874.01 – 3,900.00	150
1,456.00 – 1,494.99	59	2,704.01 – 2,730.00	105	3,900.01 – 3,926.00	151
1,495.00 – 1,520.99	60	2,730.01 – 2,756.00	106	3,926.01 – 3,952.00	152
1,521.00 – 1,546.99	61	2,756.01 – 2,782.00	107	3,952.01 – 3,978.00	153
1,547.00 – 1,585.99	62	2,782.01 – 2,808.00	108	3,978.01 – 4,004.00	154
1,586.00 – 1,611.99	63	2,808.01 – 2,834.00	109	4,004.01 – 4,030.00	155
1,612.00 – 1,637.99	64	2,834.01 – 2,860.00	110	4,030.01 – 4,056.00	156
1,638.00 – 1,676.99	65	2,860.01 – 2,886.00	111	4,056.01 – 4,082.00	157
1,677.00 – 1,702.99	66	2,886.01 – 2,912.00	112	4,082.01 – 4,108.00	158
1,703.00 – 1,741.99	67	2,912.01 – 2,938.00	113	4,108.01 – 4,134.00	159
1,742.00 – 1,767.99	68	2,938.01 – 2,964.00	114	4,134.01 – 4,160.00	160
1,768.00 – 1,806.99	69	2,964.01 – 2,990.00	115	4,160.01 – 4,186.00	161
1,807.00 – 1,832.99	70	2,990.01 – 3,016.00	116	4,186.01 – 4,212.00	162
1,833.00 – 1,846.00	71	3,016.01 – 3,042.00	117	4,212.01 – 4,238.00	163
1,846.01 – 1,872.00	72	3,042.01 – 3,068.00	118	4,238.01 – 4,264.00	164
1,872.01 – 1,898.00	73	3,068.01 – 3,094.00	119	4,264.01 – 4,290.00	165
1,898.01 – 1,924.00	74	3,094.01 – 3,120.00	120	4,290.01 – 4,316.00	166
1,924.01 – 1,950.00	75	3,120.01 – 3,146.00	121	4,316.01 – 4,342.00	167
1,950.01 – 1,976.00	76	3,146.01 – 3,172.00	122	4,342.01 – 4,368.00	168
1,976.01 – 2,002.00	77	3,172.01 – 3,198.00	123	4,368.01 – 4,394.00	169
2,002.01 – 2,028.00	78	3,198.01 – 3,224.00	124	4,394.01 – 4,420.00	170
2,028.01 – 2,054.00	79	3,224.01 – 3,250.00	125	4,420.01 – 4,446.00	171
2,054.01 – 2,080.00	80	3,250.01 – 3,276.00	126	4,446.01 – 4,472.00	172
2,080.01 – 2,106.00	81	3,276.01 – 3,302.00	127	4,472.01 – 4,498.00	173
2,106.01 – 2,132.00	82	3,302.01 – 3,328.00	128	4,498.01 – 4,524.00	174
2,132.01 – 2,158.00	83	3,328.01 – 3,354.00	129	4,524.01 – 4,550.00	175
2,158.01 – 2,184.00	84	3,354.01 – 3,380.00	130	4,550.01 – 4,576.00	176
2,184.01 – 2,210.00	85	3,380.01 – 3,406.00	131	4,576.01 – 4,602.00	177

Unemployment Insurance Benefit Table For New Claims with a Beginning Date of January 2, 2005 or After

Amount of Wages in Highest Quarter	Weekly Benefit Amount	Amount of Wages in Highest Quarter	Weekly Benefit Amount	Amount of Wages in Highest Quarter	Weekly Benefit Amount
\$ 4,602.01 – 4,628.00	... \$178	\$ 5,798.01 – 5,824.00	... \$224	\$ 6,994.01 – 7,020.00	... \$270
4,628.01 – 4,654.00	..... 179	5,824.01 – 5,850.00	..... 225	7,020.01 – 7,046.00	..... 271
4,654.01 – 4,680.00	..... 180	5,850.01 – 5,876.00	..... 226	7,046.01 – 7,072.00	..... 272
4,680.01 – 4,706.00	..... 181	5,876.01 – 5,902.00	..... 227	7,072.01 – 7,098.00	..... 273
4,706.01 – 4,732.00	..... 182	5,902.01 – 5,928.00	..... 228	7,098.01 – 7,124.00	..... 274
4,732.01 – 4,758.00	..... 183	5,928.01 – 5,954.00	..... 229	7,124.01 – 7,150.00	..... 275
4,758.01 – 4,784.00	..... 184	5,954.01 – 5,980.00	..... 230	7,150.01 – 7,176.00	..... 276
4,784.01 – 4,810.00	..... 185	5,980.01 – 6,006.00	..... 231	7,176.01 – 7,202.00	..... 277
4,810.01 – 4,836.00	..... 186	6,006.01 – 6,032.00	..... 232	7,202.01 – 7,228.00	..... 278
4,836.01 – 4,862.00	..... 187	6,032.01 – 6,058.00	..... 233	7,228.01 – 7,254.00	..... 279
4,862.01 – 4,888.00	..... 188	6,058.01 – 6,084.00	..... 234	7,254.01 – 7,280.00	..... 280
4,888.01 – 4,914.00	..... 189	6,084.01 – 6,110.00	..... 235	7,280.01 – 7,306.00	..... 281
4,914.01 – 4,940.00	..... 190	6,110.01 – 6,136.00	..... 236	7,306.01 – 7,332.00	..... 282
4,940.01 – 4,966.00	..... 191	6,136.01 – 6,162.00	..... 237	7,332.01 – 7,358.00	..... 283
4,966.01 – 4,992.00	..... 192	6,162.01 – 6,188.00	..... 238	7,358.01 – 7,384.00	..... 284
4,992.01 – 5,018.00	..... 193	6,188.01 – 6,214.00	..... 239	7,384.01 – 7,410.00	..... 285
5,018.01 – 5,044.00	..... 194	6,214.01 – 6,240.00	..... 240	7,410.01 – 7,436.00	..... 286
5,044.01 – 5,070.00	..... 195	6,240.01 – 6,266.00	..... 241	7,436.01 – 7,462.00	..... 287
5,070.01 – 5,096.00	..... 196	6,266.01 – 6,292.00	..... 242	7,462.01 – 7,488.00	..... 288
5,096.01 – 5,122.00	..... 197	6,292.01 – 6,318.00	..... 243	7,488.01 – 7,514.00	..... 289
5,122.01 – 5,148.00	..... 198	6,318.01 – 6,344.00	..... 244	7,514.01 – 7,540.00	..... 290
5,148.01 – 5,174.00	..... 199	6,344.01 – 6,370.00	..... 245	7,540.01 – 7,566.00	..... 291
5,174.01 – 5,200.00	..... 200	6,370.01 – 6,396.00	..... 246	7,566.01 – 7,592.00	..... 292
5,200.01 – 5,226.00	..... 201	6,396.01 – 6,422.00	..... 247	7,592.01 – 7,618.00	..... 293
5,226.01 – 5,252.00	..... 202	6,422.01 – 6,448.00	..... 248	7,618.01 – 7,644.00	..... 294
5,252.01 – 5,278.00	..... 203	6,448.01 – 6,474.00	..... 249	7,644.01 – 7,670.00	..... 295
5,278.01 – 5,304.00	..... 204	6,474.01 – 6,500.00	..... 250	7,670.01 – 7,696.00	..... 296
5,304.01 – 5,330.00	..... 205	6,500.01 – 6,526.00	..... 251	7,696.01 – 7,722.00	..... 297
5,330.01 – 5,356.00	..... 206	6,526.01 – 6,552.00	..... 252	7,722.01 – 7,748.00	..... 298
5,356.01 – 5,382.00	..... 207	6,552.01 – 6,578.00	..... 253	7,748.01 – 7,774.00	..... 299
5,382.01 – 5,408.00	..... 208	6,578.01 – 6,604.00	..... 254	7,774.01 – 7,800.00	..... 300
5,408.01 – 5,434.00	..... 209	6,604.01 – 6,630.00	..... 255	7,800.01 – 7,826.00	..... 301
5,434.01 – 5,460.00	..... 210	6,630.01 – 6,656.00	..... 256	7,826.01 – 7,852.00	..... 302
5,460.01 – 5,486.00	..... 211	6,656.01 – 6,682.00	..... 257	7,852.01 – 7,878.00	..... 303
5,486.01 – 5,512.00	..... 212	6,682.01 – 6,708.00	..... 258	7,878.01 – 7,904.00	..... 304
5,512.01 – 5,538.00	..... 213	6,708.01 – 6,734.00	..... 259	7,904.01 – 7,930.00	..... 305
5,538.01 – 5,564.00	..... 214	6,734.01 – 6,760.00	..... 260	7,930.01 – 7,956.00	..... 306
5,564.01 – 5,590.00	..... 215	6,760.01 – 6,786.00	..... 261	7,956.01 – 7,982.00	..... 307
5,590.01 – 5,616.00	..... 216	6,786.01 – 6,812.00	..... 262	7,982.01 – 8,008.00	..... 308
5,616.01 – 5,642.00	..... 217	6,812.01 – 6,838.00	..... 263	8,008.01 – 8,034.00	..... 309
5,642.01 – 5,668.00	..... 218	6,838.01 – 6,864.00	..... 264	8,034.01 – 8,060.00	..... 310
5,668.01 – 5,694.00	..... 219	6,864.01 – 6,890.00	..... 265	8,060.01 – 8,086.00	..... 311
5,694.01 – 5,720.00	..... 220	6,890.01 – 6,916.00	..... 266	8,086.01 – 8,112.00	..... 312
5,720.01 – 5,746.00	..... 221	6,916.01 – 6,942.00	..... 267	8,112.01 – 8,138.00	..... 313
5,746.01 – 5,772.00	..... 222	6,942.01 – 6,968.00	..... 268	8,138.01 – 8,164.00	..... 314
5,772.01 – 5,798.00	..... 223	6,968.01 – 6,994.00	..... 269	8,164.01 – 8,190.00	..... 315

Unemployment Insurance Benefit Table For New Claims with a Beginning Date of January 2, 2005 or After

Amount of Wages in Highest Quarter	Weekly Benefit Amount	Amount of Wages in Highest Quarter	Weekly Benefit Amount	Amount of Wages in Highest Quarter	Weekly Benefit Amount
\$ 8,190.01 – 8,216.00	... 316	\$ 9,386.01 – 9,412.00	... 362	\$10,582.01 – 10,608.00	... 408
8,216.01 – 8,242.00	..... 317	9,412.01 – 9,438.00	..... 363	10,608.01 – 10,634.00	..... 409
8,242.01 – 8,268.00	..... 318	9,438.01 – 9,464.00	..... 364	10,634.01 – 10,660.00	..... 410
8,268.01 – 8,294.00	..... 319	9,464.01 – 9,490.00	..... 365	10,660.01 – 10,686.00	..... 411
8,294.01 – 8,320.00	..... 320	9,490.01 – 9,516.00	..... 366	10,686.01 – 10,712.00	..... 412
8,320.01 – 8,346.00	..... 321	9,516.01 – 9,542.00	..... 367	10,712.01 – 10,738.00	..... 413
8,346.01 – 8,372.00	..... 322	9,542.01 – 9,568.00	..... 368	10,738.01 – 10,764.00	..... 414
8,372.01 – 8,398.00	..... 323	9,568.01 – 9,594.00	..... 369	10,764.01 – 10,790.00	..... 415
8,398.01 – 8,424.00	..... 324	9,594.01 – 9,620.00	..... 370	10,790.01 – 10,816.00	..... 416
8,424.01 – 8,450.00	..... 325	9,620.01 – 9,646.00	..... 371	10,816.01 – 10,842.00	..... 417
8,450.01 – 8,476.00	..... 326	9,646.01 – 9,672.00	..... 372	10,842.01 – 10,868.00	..... 418
8,476.01 – 8,502.00	..... 327	9,672.01 – 9,698.00	..... 373	10,868.01 – 10,894.00	..... 419
8,502.01 – 8,528.00	..... 328	9,698.01 – 9,724.00	..... 374	10,894.01 – 10,920.00	..... 420
8,528.01 – 8,554.00	..... 329	9,724.01 – 9,750.00	..... 375	10,920.01 – 10,946.00	..... 421
8,554.01 – 8,580.00	..... 330	9,750.01 – 9,776.00	..... 376	10,946.01 – 10,972.00	..... 422
8,580.01 – 8,606.00	..... 331	9,776.01 – 9,802.00	..... 377	10,972.01 – 10,998.00	..... 423
8,606.01 – 8,632.00	..... 332	9,802.01 – 9,828.00	..... 378	10,998.01 – 11,024.00	..... 424
8,632.01 – 8,658.00	..... 333	9,828.01 – 9,854.00	..... 379	11,024.01 – 11,050.00	..... 425
8,658.01 – 8,684.00	..... 334	9,854.01 – 9,880.00	..... 380	11,050.01 – 11,076.00	..... 426
8,684.01 – 8,710.00	..... 335	9,880.01 – 9,906.00	..... 381	11,076.01 – 11,102.00	..... 427
8,710.01 – 8,736.00	..... 336	9,906.01 – 9,932.00	..... 382	11,102.01 – 11,128.00	..... 428
8,736.01 – 8,762.00	..... 337	9,932.01 – 9,958.00	..... 383	11,128.01 – 11,154.00	..... 429
8,762.01 – 8,788.00	..... 338	9,958.01 – 9,984.00	..... 384	11,154.01 – 11,180.00	..... 430
8,788.01 – 8,814.00	..... 339	9,984.01 – 10,010.00	..... 385	11,180.01 – 11,206.00	..... 431
8,814.01 – 8,840.00	..... 340	10,010.01 – 10,036.00	..... 386	11,206.01 – 11,232.00	..... 432
8,840.01 – 8,866.00	..... 341	10,036.01 – 10,062.00	..... 387	11,232.01 – 11,258.00	..... 433
8,866.01 – 8,892.00	..... 342	10,062.01 – 10,088.00	..... 388	11,258.01 – 11,284.00	..... 434
8,892.01 – 8,918.00	..... 343	10,088.01 – 10,114.00	..... 389	11,284.01 – 11,310.00	..... 435
8,918.01 – 8,944.00	..... 344	10,114.01 – 10,140.00	..... 390	11,310.01 – 11,336.00	..... 436
8,944.01 – 8,970.00	..... 345	10,140.01 – 10,166.00	..... 391	11,336.01 – 11,362.00	..... 437
8,970.01 – 8,996.00	..... 346	10,166.01 – 10,192.00	..... 392	11,362.01 – 11,388.00	..... 438
8,996.01 – 9,022.00	..... 347	10,192.01 – 10,218.00	..... 393	11,388.01 – 11,414.00	..... 439
9,022.01 – 9,048.00	..... 348	10,218.01 – 10,244.00	..... 394	11,414.01 – 11,440.00	..... 440
9,048.01 – 9,074.00	..... 349	10,244.01 – 10,270.00	..... 395	11,440.01 – 11,466.00	..... 441
9,074.01 – 9,100.00	..... 350	10,270.01 – 10,296.00	..... 396	11,466.01 – 11,492.00	..... 442
9,100.01 – 9,126.00	..... 351	10,296.01 – 10,322.00	..... 397	11,492.01 – 11,518.00	..... 443
9,126.01 – 9,152.00	..... 352	10,322.01 – 10,348.00	..... 398	11,518.01 – 11,544.00	..... 444
9,152.01 – 9,178.00	..... 353	10,348.01 – 10,374.00	..... 399	11,544.01 – 11,570.00	..... 445
9,178.01 – 9,204.00	..... 354	10,374.01 – 10,400.00	..... 400	11,570.01 – 11,596.00	..... 446
9,204.01 – 9,230.00	..... 355	10,400.01 – 10,426.00	..... 401	11,596.01 – 11,622.00	..... 447
9,230.01 – 9,256.00	..... 356	10,426.01 – 10,452.00	..... 402	11,622.01 – 11,648.00	..... 448
9,256.01 – 9,282.00	..... 357	10,452.01 – 10,478.00	..... 403	11,648.01 – 11,674.00	..... 449
9,282.01 – 9,308.00	..... 358	10,478.01 – 10,504.00	..... 404	11,674.01 – and over	..... 450
9,308.01 – 9,334.00	..... 359	10,504.01 – 10,530.00	..... 405		
9,334.01 – 9,360.00	..... 360	10,530.01 – 10,556.00	..... 406		
9,360.01 – 9,386.00	..... 361	10,556.01 – 10,582.00	..... 407		

How to Get Help Online

- To learn more about EDD services and programs, visit the EDD website at www.edd.ca.gov.
- To ask us a question, access your UI Online or SDI account or visit <https://askedd.edd.ca.gov>.
- To find your nearest AJCC, visit www.americasjobcenter.ca.gov.

Phone

All of our phone numbers are toll free. For relay service, provide one of the numbers below to the operator.

Unemployment Insurance

EDD staff are available Monday through Friday between 8 a.m. and 12 noon (Pacific Time), except on state holidays.

English	1-800-300-5616	Mandarin	1-866-303-0706
Spanish	1-800-326-8937	Vietnamese	1-800-547-2058
Cantonese	1-800-547-3506	TTY	1-800-815-9387

Disability Insurance

EDD staff are available from Monday through Friday between 8 a.m. and 5 p.m. (Pacific Time), except on state holidays.

English	1-800-480-3287	Spanish	1-866-658-8846
TTY	1-800-563-2441		

Paid Family Leave

EDD staff are available from Monday through Friday between 8 a.m. and 5 p.m. (Pacific Time), except on state holidays.

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



STATE OF CALIFORNIA

LABOR AND WORKFORCE DEVELOPMENT AGENCY

EMPLOYMENT DEVELOPMENT DEPARTMENT

This publication is available on the EDD website at:
www.edd.ca.gov/pdf_pub_ctr/de2320.pdf

The EDD is an equal opportunity employer/program. Auxiliary aids and services are available upon request to individuals with disabilities. Requests for services, aids, and/or alternate formats need to be made by calling the information numbers listed in this book.



FAMILY CARE AND MEDICAL LEAVE AND PREGNANCY DISABILITY LEAVE

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

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

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

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

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

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

EMPLOYEE RIGHTS UNDER THE FAMILY AND MEDICAL LEAVE ACT

THE UNITED STATES DEPARTMENT OF LABOR WAGE AND HOUR DIVISION

LEAVE ENTITLEMENTS

Eligible employees who work for a covered employer can take up to 12 weeks of unpaid, job-protected leave in a 12-month period for the following reasons:

- The birth of a child or placement of a child for adoption or foster care;
- To bond with a child (leave must be taken within 1 year of the child's birth or placement);
- To care for the employee's spouse, child, or parent who has a qualifying serious health condition;
- For the employee's own qualifying serious health condition that makes the employee unable to perform the employee's job;
- For qualifying exigencies related to the foreign deployment of a military member who is the employee's spouse, child, or parent.

An eligible employee who is a covered servicemember's spouse, child, parent, or next of kin may also take up to 26 weeks of FMLA leave in a single 12-month period to care for the servicemember with a serious injury or illness.

An employee does not need to use leave in one block. When it is medically necessary or otherwise permitted, employees may take leave intermittently or on a reduced schedule.

Employees may choose, or an employer may require, use of accrued paid leave while taking FMLA leave. If an employee substitutes accrued paid leave for FMLA leave, the employee must comply with the employer's normal paid leave policies.

While employees are on FMLA leave, employers must continue health insurance coverage as if the employees were not on leave.

Upon return from FMLA leave, most employees must be restored to the same job or one nearly identical to it with equivalent pay, benefits, and other employment terms and conditions.

An employer may not interfere with an individual's FMLA rights or retaliate against someone for using or trying to use FMLA leave, opposing any practice made unlawful by the FMLA, or being involved in any proceeding under or related to the FMLA.

An employee who works for a covered employer must meet three criteria in order to be eligible for FMLA leave. The employee must:

- Have worked for the employer for at least 12 months;
- Have at least 1,250 hours of service in the 12 months before taking leave;* and
- Work at a location where the employer has at least 50 employees within 75 miles of the employee's worksite.

*Special "hours of service" requirements apply to airline flight crew employees.

Generally, employees must give 30-days' advance notice of the need for FMLA leave. If it is not possible to give 30-days' notice, an employee must notify the employer as soon as possible and, generally, follow the employer's usual procedures.

Employees do not have to share a medical diagnosis, but must provide enough information to the employer so it can determine if the leave qualifies for FMLA protection. Sufficient information could include informing an employer that the employee is or will be unable to perform his or her job functions, that a family member cannot perform daily activities, or that hospitalization or continuing medical treatment is necessary. Employees must inform the employer if the need for leave is for a reason for which FMLA leave was previously taken or certified.

Employers can require a certification or periodic recertification supporting the need for leave. If the employer determines that the certification is incomplete, it must provide a written notice indicating what additional information is required.

Once an employer becomes aware that an employee's need for leave is for a reason that may qualify under the FMLA, the employer must notify the employee if he or she is eligible for FMLA leave and, if eligible, must also provide a notice of rights and responsibilities under the FMLA. If the employee is not eligible, the employer must provide a reason for ineligibility.

Employers must notify its employees if leave will be designated as FMLA leave, and if so, how much leave will be designated as FMLA leave.

Employees may file a complaint with the U.S. Department of Labor, Wage and Hour Division, or may bring a private lawsuit against an employer.

The FMLA does not affect any federal or state law prohibiting discrimination or supersede any state or local law or collective bargaining agreement that provides greater family or medical leave rights.

BENEFITS & PROTECTIONS

ELIGIBILITY REQUIREMENTS

REQUESTING LEAVE

EMPLOYER RESPONSIBILITIES

ENFORCEMENT

For additional information or to file a complaint:

1-866-4-USWAGE

(1-866-487-9243) TTY: 1-877-889-5627

www.dol.gov/whd

U.S. Department of Labor | Wage and Hour Division





About California Paid Family Leave

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

Fast Facts About California Paid Family Leave

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

CALIFORNIA PAID FAMILY LEAVE

moments matter.

Paid Family Leave:

Giving Californians the benefits they need to be there for the moments that matter.

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

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

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



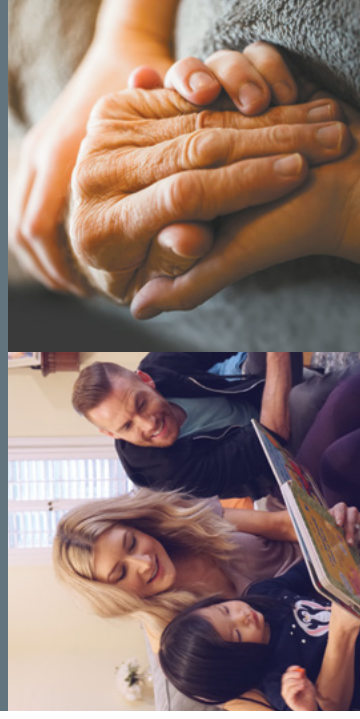
For more information, visit:
CaliforniaPaidFamilyLeave.com

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



CALIFORNIA PAID FAMILY LEAVE

Helping Californians be present for the moments that matter.



Do I Qualify For California Paid Family Leave?

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

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

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

How Are Benefit Amounts Calculated?

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

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

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

How Do I Apply For Benefits?

Apply for Paid Family Leave benefits by visiting [SDI Online \(edd.ca.gov/SDI_Online\)](#).

You may also apply using a paper form.

Visit [EDD Forms and Publications \(edd.ca.gov/Forms\)](#) to request a *Claim for Paid Family Leave (PFL) Benefits (DE 2501F)* form.

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

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

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

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

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

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

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



Does Paid Family Leave Provide Job Protection?

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

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

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



Acerca del Permiso Familiar Pagado de California

Para muchos californianos que trabajan, encontrar el tiempo para estar con un ser querido cuando mas lo necesitan puede ser difícil. El Permiso Familiar Pagado de California fue creado para esos momentos que importan, como establecer un vínculo paternal con un hijo recién integrado a la familia o cuidar a un familiar que se encuentra gravemente enfermo.

Información sobre el Permiso Familiar Pagado de California

- Proporciona beneficios que sustituyen parcialmente los sueldos del trabajador para establecer un vínculo paternal con un hijo [ya sea por nacimiento, adopción o bajo cuidado de crianza temporal (*foster care*)] o para cuidar a un familiar que se encuentra gravemente enfermo (un hijo, padre, suegro, abuelo, nieto, hermano, cónyuge, o pareja doméstica debidamente registrada).
- No es necesario que reciba los beneficios de forma consecutiva.
- Ofrece aproximadamente de 60 a 70 por ciento del sueldo del trabajador durante la ausencia laboral.
- Es financiado a través de las deducciones del impuesto del Seguro Estatal de Incapacidad (SDI), por lo tanto, será elegible si paga el impuesto del SDI (aparece en su talón de cheque como "CASDI") o ha tenido un seguro privado aprobado (*voluntary plan*) durante los últimos 5 a 18 meses.
- Puede ausentarse de su empleo para establecer un vínculo paternal con un hijo nuevo, en cualquier momento dentro de un período de 12 meses a partir de que el niño se integre a su familia.
- Su estatus migratorio o de ciudadanía no afecta su elegibilidad.

CALIFORNIA PAID FAMILY LEAVE moments matter.

Permiso Familiar Pagado:

Ofrece a los californianos los beneficios que necesitan para estar con sus seres queridos en los momentos que importan.

Español	1-877-379-3819
Inglés	1-877-238-4373
Cantonés	1-866-692-5595
Vietnamita	1-866-692-5596
Armenio	1-866-627-1567
Punyabí	1-866-627-1568
Tagalo	1-866-627-1569
TTY (Teletipo)	1-800-445-1312

Para obtener formularios impresos, recibir información o hablar con un representante, visite alguna de las oficinas del Permiso Familiar Pagado o del Seguro de Incapacidad.

Visite una oficina del Seguro Estatal de Discapacidad (edd.ca.gov/Disability/)
Contact_SDI_Espanol.htm cercana a usted.



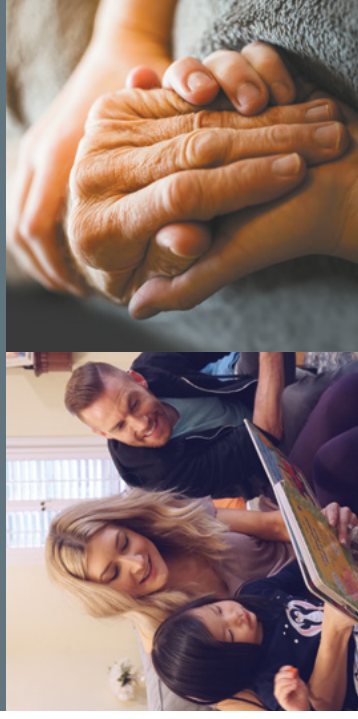
Para más información, visite CaliforniaPaidFamilyLeave.com

El EDD ofrece igualdad de oportunidad al empleo, acceso a sus programas y servicios. Servicios de asistencia para las personas con discapacidades están disponibles cuando se soliciten. Para pedir servicios, asistencia y/o formatos alternos, comuníquese al **1-866-490-8879** o por TTY (teletipo) al **711**.



PERMISO FAMILIAR PAGADO
DE CALIFORNIA

Ayudando a los californianos a estar presente en los momentos que importan.



¿Califico para el Permiso Familiar Pagado?

Para calificar para beneficios del Permiso Familiar Pagado, debe cumplir con los siguientes requisitos:

- Tener la necesidad de ausentarse de su empleo para cuidar a un familiar que se encuentra gravemente enfermo o establecer un vínculo paternal con un hijo que se acaba de integrar a la familia.
- Contar con cobertura del Seguro Estatal de Incapacidad o con un seguro privado (*voluntary plan*).
- Haber ganado por lo menos \$300 en los últimos 5 a 18 meses.
- Presentar su solicitud a más tardar en 41 días a partir de la fecha en que comience su ausencia familiar. No presente su solicitud antes de la fecha en que comience su ausencia familiar.

Su empleador le puede requerir que tome hasta 2 semanas de su tiempo acumulado de vacaciones o tiempo libre pagado. Consulte con el departamento de recursos humanos de su empleador para verificar cuales son los requisitos.

¿Cómo se calcula la cantidad de los beneficios?

El Permiso Familiar Pagado de California le ofrece de 60 a un 70 por ciento de los sueldos que estaría ganando semanalmente (desde \$50 hasta \$1,300 semanales).

La cantidad de beneficios semanales se calcula con base en el sueldo más alto que haya ganado en un trimestre, durante los últimos 5 a 18 meses antes de que comience su ausencia familiar. El EDD ofrece un método para calcular la cantidad estimada del pago de beneficios semanal que el solicitante podría recibir. Para obtener más información, visite la página de Internet (edd.ca.gov/PFL_Calculator).

Si reúne los requisitos para recibir beneficios, puede elegir como quiere recibir sus pagos: a través de la tarjeta de débito EDD Debit CardSM del Bank of America o por cheque, el cual le enviará el EDD por correo postal.

¿Cómo puedo solicitar beneficios?

Solicite beneficios del Permiso Familiar Pagado a través de **SDI Online** (edd.ca.gov/Disability/SDI_Online_Espanol.htm).

Usted también puede solicitar beneficios usando el formulario impreso titulado en inglés *Claim for Paid Family Leave Benefits* (PFL) (DE 2501F). Para ordenar electrónicamente el formulario en papel, visite la página de Internet en (edd.ca.gov/Forms).

Cuando presente una solicitud para proporcionar cuidado a un familiar, debe proporcionar una certificación médica que demuestre que la persona que recibe cuidado sufre de una condición médica seria y que requiere de su cuidado. Esta certificación debe ser completada por el médico profesional/médico que atiende a la persona que recibe el cuidado.

También se requiere la información de la persona que recibe el cuidado y su firma.

Cuando presente una solicitud para establecer un vínculo paternal, debe de incluir junto con la solicitud, la documentación que compruebe la relación entre usted y el hijo, tales como: copia del acta de nacimiento, el acuerdo de colocación para adopción o el documento que certifica que usted ha sido aprobado para el cuidado de un niño bajo el programa de crianza temporal (*foster care*).

Si usted actualmente está recibiendo beneficios del Seguro de Incapacidad debido a un embarazo, no es necesario que pida la solicitud para el Permiso Familiar Pagado. La solicitud para establecer un vínculo paternal se le enviará automáticamente a través de su cuenta de SDI Online o por correo postal cuando su solicitud de beneficios del Seguro de Incapacidad debido a un embarazo termine.

Si usted tiene un seguro privado (*voluntary plan*), comuníquese con su empleador para obtener información acerca de su cobertura y las instrucciones sobre cómo solicitar beneficios.

Si se determina que no reúne los requisitos para recibir beneficios, tiene derecho a:

- Conocer el motivo por el cual se le están negando los beneficios.
- Apelar la resolución sobre su elegibilidad para beneficios. Para más información acerca del proceso de apelación, visite (edd.ca.gov/Disability/Appeals.htm).

Toda la información es confidencial, excepto la que sea para propósitos permitidos por la ley.



¿Ofrece protección de empleo el Permiso Familiar Pagado?

El Permiso Familiar Pagado no ofrece protección de empleo ni le garantiza el derecho de regresar a su empleo.

Sin embargo, su empleo podría estar protegido por otras leyes, tales como la Ley de Ausencia Familiar y Médica (FMLA), la Ley de Derechos de la Familia de California (CFRA) o bajo ley titulada en inglés *New Parent Leave Act* (si califica).

Usted debe notificar a su empleador acerca de sus planes y la razón para ausentarse de su empleo, de acuerdo con las políticas de la empresa.



THE MISSION OF THE DEPARTMENT OF FAIR EMPLOYMENT AND HOUSING IS TO PROTECT THE PEOPLE OF CALIFORNIA FROM UNLAWFUL DISCRIMINATION IN EMPLOYMENT, HOUSING AND PUBLIC ACCOMMODATIONS, AND FROM THE PERPETRATION OF ACTS OF HATE VIOLENCE AND HUMAN TRAFFICKING.

SEXUAL HARASSMENT INCLUDES MANY FORMS OF OFFENSIVE BEHAVIORS BEHAVIORS THAT MAY BE SEXUAL HARASSMENT:

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

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

Employees or job applicants who believe that they have been sexually harassed or retaliated against may file a complaint of discrimination with DFEH within one year of the last act of harassment or retaliation. DFEH serves as a neutral fact-finder and attempts to help the parties voluntarily resolve disputes. If DFEH finds sufficient evidence to establish that discrimination occurred and settlement efforts fail, the Department may file a civil complaint in state or federal court to address the causes of the discrimination and on behalf of the complaining party. DFEH may seek court orders changing the employer's policies and practices, punitive damages, and attorney's fees and costs if it prevails in litigation. Employees can also pursue the matter through a private lawsuit in civil court after a complaint has been filed with DFEH and a Right-to-Sue Notice has been issued.

THE FACTS

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

THERE ARE TWO TYPES OF SEXUAL HARASSMENT

- ① *"Quid pro quo"* (Latin for "this for that") sexual harassment is when someone conditions a job, promotion, or other work benefit on your submission to sexual advances or other conduct based on sex.
- ② *"Hostile work environment"* sexual harassment occurs when unwelcome comments or conduct based on sex unreasonably interfere with your work performance or create an intimidating, hostile, or offensive work environment. You may experience sexual harassment even if the offensive conduct was not aimed directly at you.

The harassment must be severe or pervasive to be unlawful. That means that it alters the conditions of your employment and creates an abusive work environment. A single act of harassment may be sufficiently severe to be unlawful.

FOR MORE INFORMATION

Department of Fair Employment and Housing
Toll Free: (800) 884-1684
TTY: (800) 700-2320
Online: www.dfeh.ca.gov

Also find us on:



If you have a disability that prevents you from submitting a written intake form on-line, by mail, or email, the DFEH can assist you by scribing your intake by phone or, for individuals who are Deaf or Hard of Hearing or have speech disabilities, through the California Relay Service (711), or call us through your VRS at (800) 884-1684 (voice).

To schedule an appointment, contact the Communication Center at (800) 884-1684 (voice or via relay operator 711) or (800) 700-2320 (TTY) or by email at contact.center@dfeh.ca.gov.

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

Contact the DFEH at (800) 884-1684 (voice or via relay operator 711), TTY (800) 700-2320, or contact.center@dfeh.ca.gov to discuss your preferred format to access our materials or webpages.



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

- Indicate that when the employer receives allegations of misconduct, it will conduct a fair, timely, and thorough investigation that provides all parties appropriate due process and reaches reasonable conclusions based on the evidence collected.
- Make clear that employees shall not be retaliated against as a result of making a complaint or participating in an investigation.
- ④ Distribute its harassment, discrimination, and retaliation prevention policy by doing one or more of the following:
 - Printing the policy and providing a copy to employees with an acknowledgement form for employees to sign and return.
 - Sending the policy via email with an acknowledgment return form.
 - Posting the current version of the policy on a company intranet with a tracking system to ensure all employees have read and acknowledged receipt of the policy.
 - Discussing policies upon hire and/or during a new hire orientation session.
 - Using any other method that ensures employees received and understand the policy.
- ⑤ If the employer's workforce at any facility or establishment contains ten percent or more of persons who speak a language other than English as their spoken language, that employer shall translate the harassment, discrimination, and retaliation policy into every language spoken by at least ten percent of the workforce.
- ⑥ In addition, employers who do business in California and employ 5 or more part-time or full-time employees must provide at least one hour of training regarding the prevention of sexual harassment, including harassment based on gender identity, gender expression, and sexual orientation, to each non-supervisory employee; and two hours of such training to each supervisory employee. Training must be provided within six months of assumption of employment. Employees must be trained during calendar year 2019, and, after January 1, 2020, training must be provided again every two years. Please see Gov. Code 12950.1 and 2 CCR 11024 for further information.

CIVIL REMEDIES:

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

EMPLOYER RESPONSIBILITY & LIABILITY

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

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

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

- ① Distribute copies of this brochure or an alternative writing that complies with Government Code 12950. This pamphlet may be duplicated in any quantity.
- ② Post a copy of the Department's employment poster entitled "California Law Prohibits Workplace Discrimination and Harassment."
- ③ Develop a harassment, discrimination, and retaliation prevention policy in accordance with 2 CCR 11023. The policy must:
 - Be in writing.
 - List all protected groups under the FEHA.
 - Indicate that the law prohibits coworkers and third parties, as well as supervisors and managers with whom the employee comes into contact, from engaging in prohibited harassment.
 - Create a complaint process that ensures confidentiality to the extent possible; a timely response; an impartial and timely investigation by qualified personnel; documentation and tracking for reasonable progress; appropriate options for remedial actions and resolutions; and timely closures.
 - Provide a complaint mechanism that does not require an employee to complain directly to their immediate supervisor. That complaint mechanism must include, but is not limited to including: provisions for direct communication, either orally or in writing, with a designated company representative; and/or a complaint hotline; and/or access to an ombudsperson; and/or identification of DFEH and the United States Equal Employment Opportunity Commission as additional avenues for employees to lodge complaints.
 - Instruct supervisors to report any complaints of misconduct to a designated company representative, such as a human resources manager, so that the company can try to resolve the claim internally. Employers with 50 or more employees are required to include this as a topic in mandated sexual harassment prevention training (see 2 CCR 11024).

EL ACOSO SEXUAL INCLUYE MUCHAS FORMAS DE CONDUCTAS OFENSIVAS

CONDUCTAS QUE PUEDEN SER ACOSO SEXUAL:

- 1 *Insinuaciones de índole sexual indeseadas*
- 2 *Ofrecimiento de beneficios laborales a cambio de favores sexuales*
- 3 *Miradas lascivas; gestos de tipo sexual; o exhibir objetos sexualmente insinuantes, como fotografías, caricaturas o pósteres*
- 4 *Comentarios despectivos, epítetos, agravios o bromas*
- 5 *Comentarios gráficos, términos sexualmente denigrantes o mensajes o invitaciones insinuantes*
- 6 *Manoseo o agresión física, como también impedir u obstruir movimientos*

LA MISIÓN DEL DEPARTAMENTO DE IGUALDAD EN EL EMPLEO Y LA VIVIENDA ES PROTEGER A LOS HABITANTES DE CALIFORNIA DE DISCRIMINACIÓN ILÍCITA EN EL EMPLEO, LA VIVIENDA Y SERVICIOS PÚBLICOS, Y DE LA PERPETRACIÓN DE ACTOS DE VIOLENCIA POR ODIO Y TRATA DE PERSONAS.



ACOSO SEXUAL

PARA MÁS INFORMACIÓN

Departamento De Igualdad En El Empleo Y La Vivienda

Línea gratuita: (800) 884-1684

TTY: (800) 700-2320

En línea: www.dfeh.ca.gov

O *encuéntrenos en:*



Si usted tiene una discapacidad que le impide enviar un formulario inicial por escrito en línea, correo postal o correo electrónico, DFEH puede asistirlo escribiendo su formulario inicial por teléfono o, para individuos que son sordos o hipoacúsicos o que tienen discapacidades del habla, a través del Servicio de Retransmisión de California (711), o llámenos por su VRS al (800) 884-1684 (voz).

Para programar una cita, comuníquese con el Centro de Comunicaciones al (800) 884-1684 (voz o vía operador de retransmisión 711) o al (800) 700-2320 (TTY) o por correo electrónico al contact.center@dfeh.ca.gov.

DFEH está comprometido a proporcionar acceso a nuestros materiales en un formato alternativo como adaptación razonable para individuos con discapacidades según sea solicitado.

Comuníquese con DFEH al (800) 884-1684 (voz o vía operador de retransmisión 711), TTY (800) 700-2320 o contact.center@dfeh.ca.gov para conversar sobre su formato de preferencia para acceder a nuestros materiales o páginas web.

LA REALIDAD SOBRE EL ACOSO SEXUAL

El acoso sexual es una forma de discriminación que se basa en el sexo o el género (incluyendo el embarazo, el parto o estado de salud relacionado con los mismos), identidad de género, expresión de género u orientación sexual. Individuos de cualquier género pueden ser víctimas de acoso sexual. El acoso sexual ilícito no necesariamente tiene que estar motivado por el interés sexual. El acoso sexual puede involucrar el acoso de una persona del mismo género del acosador(a), independientemente de la orientación sexual o identidad de género de cualquiera de las personas.

HAY DOS TIPOS DE ACOSO SEXUAL

- ① *El acoso sexual “quid pro quo” (“esto por aquello” en latín) ocurre cuando alguien ofrece un trabajo, ascenso u otro beneficio laboral a cambio de la aceptación de propuestas sexuales u otra conducta de índole sexual.*
- ② *El acoso sexual de “ambiente laboral hostil” ocurre cuando comentarios o conductas indeseadas de índole sexual interfieren de manera inaceptable en su desempeño laboral o crean un ambiente laboral intimidante, hostil o agravante. Usted puede ser víctima de acoso sexual incluso si la conducta ofensiva no estaba dirigida especialmente a usted.*

El acoso debe ser severo o generalizado para ser considerado ilegal. Esto significa que altera las condiciones de su empleo y crea un ambiente laboral abusivo. Un solo acto de acoso puede ser suficientemente grave para ser ilegal.

RECURSOS CIVILES:



- 1 *Compensaciones por sufrimiento emocional causado por cada empleador o individuo que viole la ley*
- 2 *Empleo o restitución del empleo*
- 3 *Pago retroactivo o ascenso*
- 4 *Cambios en las pólizas políticas o prácticas del empleador*

RESPONSABILIDAD DEL EMPLEADOR

Todos los empleadores, independientemente de la cantidad de empleados, están incluidos en las disposiciones sobre acoso sexual de las leyes de California. Los empleadores son responsables por los actos de acoso cometidos por sus supervisores o agentes. Todos los acosadores, incluyendo el personal de supervisión como el personal sin responsabilidad de supervisión pueden ser considerados responsables de acoso o por ayudar y ser cómplices de acoso sexual. La ley requiere que los empleadores tomen medidas razonables para prevenir el acoso sexual. Si un empleador falla con tomar tales medidas, ese empleador puede ser considerado responsable por el acto de acoso. Además, un empleador puede ser responsable por el acoso realizado por una persona ajena a la empresa (por ejemplo, un comprador o cliente de un empleado, un postulante a un empleo o una persona que brinda servicios al empleador). Un empleador solo será sujeto a responsabilidad por esta forma de acoso si sabía o debería haber tenido conocimiento del acto de acoso, y no tomó las acciones correctivas inmediatas.

Los empleadores tienen el deber concreto de adoptar medidas razonables para impedir y corregir sin demora conductas discriminadoras y acosadora, y crear un ambiente laboral libre de sin acoso.

Un programa para eliminar el acoso sexual del ambiente laboral no solo es obligatorio por ley, sino que es la vía más práctica para un empleador para evitar o limitar la responsabilidad si ocurriera un acto de acoso sexual.

TODOS LOS EMPLEADORES DEBEN ADOPTAR LAS SIGUIENTES MEDIDAS PARA PREVENIR EL ACOSO SEXUAL Y CORREGIRLO CUANDO SUCEDA:

- 1 Distribuir copias de este folleto o un documento alternativo que cumpla con los requisitos del artículo 12950 del Código de Gobierno. Este folleto puede ser duplicado en cualquier cantidad.
- 2 Colocar una copia del póster de empleo del Departamento titulado "La Ley de California Prohíbe la Discriminación y el Acoso Sexual en el Lugar de Trabajo."
- 3 Elaborar una política de prevención de acoso sexual, discriminación y represalias de acuerdo con 2 CCR 11023. La póliza debe:
 - Estar por escrito.
 - Enumerar todos los grupos protegidos por FEHA.
 - Indicar que la ley prohíbe a compañeros de trabajo y terceros, así como a supervisores y gerentes con quienes el empleado tiene contacto, realizar actos de acoso sexual.
 - Crear un proceso de interposición de quejas que asegure confidencialidad al máximo posible; una respuesta oportuna; una investigación imparcial y puntual por parte de personal cualificado; documentación y registro de progreso adecuado; opciones adecuadas para medidas correctivas y resoluciones; y soluciones oportunas.
 - Proporcionar un mecanismo de interposición de quejas que no requiera que un empleado tenga que quejarse directamente ante su supervisor inmediato. Ese mecanismo de interposición de quejas debe incluir, pero sin limitarse a: disposiciones para comunicación directa ya sea oral o por escrito, con un representante designado de la empresa; y/o una línea telefónica para hacer quejas; y/o acceso a un defensor; y/o identificación de DFEH y la Comisión para la Igualdad de Oportunidades en el Empleo de los Estados Unidos como vías adicionales para que los empleados presenten reclamos.
 - Instruir a supervisores para que informen de cualquier queja de falta de ética laboral a un representante designado de la empresa, como un gerente de recursos humanos, de modo que la compañía pueda tratar de resolver la queja internamente. Los empleadores con 50 o más empleados tienen la obligación de incluir esto como tema en la capacitación obligatoria de prevención de acoso sexual (ver 2 CCR 11024).
 - Indicar que cuando el empleador reciba denuncias de falta de ética laboral, conducirá una investigación
- 4 Distribuir su póliza de prevención de acoso, discriminación y represalia haciendo uno o más de lo siguiente:
 - Dejar claro que los empleados no sufrirán represalias como resultado de presentar una queja o por participar en una investigación.
 - Distribuir su póliza de prevención de acoso, discriminación y represalia haciendo uno o más de lo siguiente:
 - Imprimir la política y proporcionar una copia a los empleados con un formulario una forma de acuse reconocimiento de recibo para que los empleados la firmen y devuelvan.
 - Enviar la póliza política por correo electrónico con una forma de reconocimiento de recibo.
 - Colocar el póster de la versión actual de la póliza en una intranet de la empresa con un sistema de rastreo para asegurar que todos los empleados hayan leído y reconozcan que han recibido la póliza acusado recibo de la política.
 - Discutir las pólizas políticas al momento de la contratación y/o durante la sesión de orientación para nuevos empleados.
 - Usar cualquier otro método para asegurar que los empleados hayan recibido y entendido la póliza.
- 5 Si los trabajadores del empleador en cualquier planta o establecimiento forman el diez por ciento o más de personas que hablan un idioma distinto del inglés como lengua materna, ese empleador deberá traducir la política sobre acoso, discriminación y represalia en cada idioma hablado por al menos el diez por ciento de los empleados.
- 6 Además, los empleadores que realizan actividades en California y emplean 5 o más empleados de tiempo parcial o de tiempo completo deben ofrecer al menos una hora de capacitación sobre la prevención del acoso sexual, que incluye acoso basado en la identidad de género, expresión de género y orientación sexual, a cada empleado que no esté en un puesto de supervisión; y dos horas de dicha capacitación a cada empleado en un puesto de supervisión. La capacitación debe brindarse dentro de los seis meses del comienzo de las funciones. Los empleados deben realizar la capacitación durante el año calendario 2019, y después del 1.º de enero de 2020, se debe proporcionar la capacitación nuevamente cada dos años. Sírvase consultar Cód. de Gov. 12950.1 y 2 CCR 11024 por más información.

justa, oportuna y completa que brinde a todas las partes el debido procesocorrespondiente y llegue a conclusiones aceptables basadas en la evidencia reunida.

- Dejar claro que los empleados no sufrirán represalias como resultado de presentar una queja o por participar en una investigación.

4 Distribuir su póliza de prevención de acoso, discriminación y represalia haciendo uno o más de lo siguiente:

- Imprimir la política y proporcionar una copia a los empleados con un formulario una forma de acuse reconocimiento de recibo para que los empleados la firmen y devuelvan.
- Enviar la póliza política por correo electrónico con una forma de reconocimiento de recibo.
- Colocar el póster de la versión actual de la póliza en una intranet de la empresa con un sistema de rastreo para asegurar que todos los empleados hayan leído y reconozcan que han recibido la póliza acusado recibo de la política.
- Discutir las pólizas políticas al momento de la contratación y/o durante la sesión de orientación para nuevos empleados.
- Usar cualquier otro método para asegurar que los empleados hayan recibido y entendido la póliza.

5 Si los trabajadores del empleador en cualquier planta o establecimiento forman el diez por ciento o más de personas que hablan un idioma distinto del inglés como lengua materna, ese empleador deberá traducir la política sobre acoso, discriminación y represalia en cada idioma hablado por al menos el diez por ciento de los empleados.

6 Además, los empleadores que realizan actividades en California y emplean 5 o más empleados de tiempo parcial o de tiempo completo deben ofrecer al menos una hora de capacitación sobre la prevención del acoso sexual, que incluye acoso basado en la identidad de género, expresión de género y orientación sexual, a cada empleado que no esté en un puesto de supervisión; y dos horas de dicha capacitación a cada empleado en un puesto de supervisión. La capacitación debe brindarse dentro de los seis meses del comienzo de las funciones. Los empleados deben realizar la capacitación durante el año calendario 2019, y después del 1.º de enero de 2020, se debe proporcionar la capacitación nuevamente cada dos años. Sírvase consultar Cód. de Gov. 12950.1 y 2 CCR 11024 por más información.

LACTATION ACCOMMODATION

The Company complies with the California Lactation Accommodation law and shall provide a reasonable amount of break time to accommodate an employee desiring to express breastmilk for the employee's infant child. The Company does not discriminate or retaliate against employees for exercising their right to request lactation accommodation.

The Company shall provide an employee with the use of a room or other location for the employee to express milk in private. A lactation room or location shall not be a bathroom and shall be in close proximity to the employee's work area, shielded from view, and free from intrusion while the employee is expressing milk. Where a multipurpose room is used for lactation among other uses, the employee requesting use for lactation purposes must take precedence and priority over all other personnel and uses. The lactation room or location provided shall comply with all of the following requirements:

The lactation room shall:

- Be safe, clean, and free of hazardous materials;
- Contain a surface to place a breast pump and personal items;
- Contain a place to sit;
- Have access to electricity or alternative devices, including, but not limited to, extension cords or charging stations needed to operate an electric or battery-powered breast pump; and
- Have access to a sink with running water and a refrigerator suitable for storing milk in close proximity to the employee's workspace. If a refrigerator cannot be provided, the Company will provide another cooling device suitable for storing milk, such as a cooler.

Employees in need of a lactation room are encouraged to contact the Human Resources Department to discuss accommodation arrangements as soon as they determine that accommodations will be needed.

The break time shall, if possible, run concurrently with any break time already provided to the employee. Any additional break time provided as an accommodation that does not run concurrently with the employee's regularly-allocated break will be unpaid.

If the Company is unable to provide break time or a location that complies with this policy, the Company will provide such a written response to the employee in writing.

The employee has a right to file a complaint with the Labor Commissioner for any violation of her lactation accommodation rights.

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

**RIGHTS OF VICTIMS OF DOMESTIC VIOLENCE,
SEXUAL ASSAULT AND STALKING**

Your Right to Take Time Off:

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

Your Right to Reasonable Accommodation:

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

Your Right to Be Free from Retaliation and Discrimination:

Your employer cannot treat you differently or fire you because:

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

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

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

EMPLOYEE RELATIONS POLICY WITH ACKNOWLEDGMENT

A. POLICY AGAINST DISCRIMINATION

_____ (the “Company”) is committed to providing a work environment that is free of discrimination. In keeping with this commitment, the Company maintains a strict policy prohibiting unlawful discrimination and retaliation. This policy applies to all employees of the Company, including supervisors and non-supervisory employees. The policy also prohibits unlawful discrimination and retaliation by non-employees of the Company with whom employees come into contact, including clients, customers, vendors and any other person doing business with the Company.

All aspects of employment with the Company will be governed on the basis of merit, competence and qualifications and will not be influenced in any manner by an individual’s race (including hair texture and protective hairstyles, such as braids, locks and twists), ancestry, color, religious creed (including religious dress and grooming practices), national origin, marital status, sex (including sexual harassment), sexual orientation, gender, gender identity, gender expression, disability (physical or mental including HIV/AIDS diagnosis), pregnancy (including breastfeeding and conditions related to breastfeeding), medical condition (cancer and genetic characteristics), age (40 or over), military and veteran status, or exercising the right to any legally provided leave of absence in the application of any policy, practice, rule or regulation.

All decisions made with respect to recruiting and hiring, evaluations and promotions for all job classifications will be based solely on individual qualifications as related to the requirements of the position. Likewise, all other personnel matters such as compensation, benefits, transfers, lay-offs, training, educational opportunities and programs will be administered free from any illegal discriminatory practices.

B. POLICY AGAINST HARASSMENT, INCLUDING SEXUAL HARASSMENT

The Company is also committed to providing a work environment that is free of harassment, including sexual harassment.

Sexual harassment includes:

1. Unwanted sexual advances;
2. Offering employment benefits in exchange for sexual favors;
3. Making or threatening reprisals after a negative response to sexual advances;
4. Visual conduct: leering, making sexual gestures, displaying of sexually suggestive objects or pictures, cartoons or posters;
5. Verbal conduct: making or using derogatory comments, epithets, slurs, and jokes;
6. Verbal sexual advances or propositions;
7. Verbal abuse of a sexual nature, graphic verbal commentaries about an individual’s body, sexually degrading words used to describe an individual, suggestive or obscene letters, notes, or

invitations;

8. Physical conduct: touching, assault, impeding or blocking movement; and

9. Further, the Company prohibits abusive conduct (“bullying”): Any form of abusive conduct by an employee in the workplace, with malice, that a reasonable person would find hostile, offensive, and unrelated to the Company’s business interest.

C. COMPLAINT AND INVESTIGATION PROCEDURE

Any form of discrimination, retaliation or harassment, including sexual harassment, is absolutely prohibited. Any incident of possible discrimination, retaliation or harassment should be brought immediately to the attention of the Human Resources Department of the Company, either verbally or in writing, which will thoroughly investigate the matter. Supervisors who receive complaints of discrimination, retaliation or harassment from their employees are required to forward those complaints to the Human Resources Department.

The Company will conduct a fair, impartial, and thorough investigation by qualified personnel that provides all parties appropriate due process. The investigation shall be conducted confidentially to the extent confidentiality is possible. The Company will document and track the progress of the investigation. The Company will make a reasonable determination, after reviewing all the evidence collected, concerning whether misconduct occurred. The investigation will be completed in a timely manner and the employee who filed the complaint will receive a timely response. If misconduct is found to have occurred, appropriate remedial measures will be taken. Disciplinary action, up to and including discharge, will be taken against any employee who is found to have engaged in conduct prohibited by this policy.

No employee shall be subjected to any form of retaliation for reporting any violation of this policy truthfully and in good faith, or for participating in any investigation conducted pursuant to this policy.

HARASSMENT BY NON-EMPLOYEES

In addition, the Company will take all reasonable steps to prevent or eliminate sexual harassment by non-employees including customers, clients and suppliers who are likely to have workplace conduct with our employees.

EMPLOYEE RELATIONS POLICY ACKNOWLEDGMENT

I have read and received a copy of the Company’s Employee Relations Policy, including the policies against discrimination, retaliation and harassment, including sexual harassment, and fully understand my obligations and responsibilities as outlined therein.

Signed: _____

Date: _____

Witness: _____

Date: _____

POLÍTICA DE RELACIONES DE EMPLEADOS CON RECONOCIMIENTO

A. POLÍTICA CONTRA LA DISCRIMINACIÓN

La Compañía está comprometida a proveer un ambiente libre de discriminación. Para cumplir con este compromiso, la Compañía mantiene una política estricta prohibiendo la discriminación y las represalias ilegales. Esta política se aplica a todos los empleados de la Compañía, incluyendo supervisores y empleados que no son de supervisión. La política también prohíbe la discriminación y las represalias de parte de personas que no son empleadas por la Compañía y con las cuales los empleados tienen contacto, incluyendo clientes, suministradores, vendedores y cualquier otra persona que haga negocio con la Compañía.

Todos los aspectos del empleo con la Compañía se regirán sobre la base del mérito, la competencia y las cualificaciones y no se verán influenciados de ninguna manera por la raza de un individuo (incluyendo la textura del cabello y los peinados protectores, tales como trenzas, mechones y giros), ascendencia, color, credo religioso (incluyendo ropa religiosa y prácticas de aseo), origen nacional, estado civil, sexo (incluyendo acoso sexual), orientación sexual, género, identidad de género, Diagnóstico del VIH/SIDA), embarazo (incluida la lactancia materna y condiciones relacionadas con la lactancia materna), condición médica (cáncer y características genéticas), edad (40 o más), estado militar y veterano, o ejercicio del derecho a cualquier licencia de ausencia legalmente proporcionada en la aplicación de cualquier política, práctica, regla o regulación.

Todas las decisiones hechas acerca de reclutamiento y empleo, evaluaciones y promociones para todas las clasificaciones de trabajo serán basadas solamente en las capacidades individuales relacionadas a los requisitos de la posición. Igualmente, todos los demás asuntos del personal como compensación, beneficios, transferencias, despido temporal, entrenamiento, oportunidades y programas educativos serán administrados libres de cualquier práctica discriminatoria ilegal.

B. POLÍTICA CONTRA EL HOSTIGAMIENTO, INCLUYENDO ACOSO SEXUAL

La Compañía también está comprometida a proveer un ambiente de trabajo libre de hostigamiento, incluyendo el acoso sexual.

Acoso sexual incluye:

1. Avances sexuales no deseados;
2. Ofrecer beneficios de empleo a cambio de favores sexuales;
3. Tomar o amenazar de tomar represalias después de recibir una respuesta negativa a un avance sexual;
4. Conducta visual: mirada de reojo lasciva; gestos sexuales; desplegar objetos o retratos, caricaturas o carteles sexualmente sugestivos;
5. Conducta verbal: hacer o usar comentarios, epítetos, calumnias o chistes derogatorios;
6. Avances o proposiciones sexuales verbales;
7. Abuso verbal de naturaleza sexual, comentarios gráficos verbales acerca del cuerpo de un individuo, palabras sexualmente degradantes usadas para describir a un individuo, cartas, notas o invitaciones obscenas o sugestivas;

8. Conducta física: tocar, asaltar, impedir u obstruir el movimiento; y
9. Además, la Compañía prohíbe la conducta abusiva ("bullying"): Cualquier forma de conducta abusiva por un empleado en el lugar de trabajo, con malicia, que una persona razonable encontraría hostil, ofensivo y sin relación al interés de negocio de la Compañía.

C. PROCEDIMIENTO DE QUEJA E INVESTIGACIÓN

Cualquier tipo de discriminación, represalia u hostigamiento, incluyendo el acoso sexual, es absolutamente prohibido. Cualquier incidente de discriminación, represalia u hostigamiento debe ser comunicado inmediatamente al Departamento de Recursos Humanos de la Compañía, ya sea verbalmente o por escrito, el cual investigará el asunto meticulosamente. Supervisores que reciben quejas de discriminación, represalias u hostigamiento de un empleado están requeridos enviar esas quejas al Departamento de Recursos Humanos.

La Compañía llevará a cabo una investigación justa, imparcial y exhaustiva a través de personal cualificado que provee proceso debido (due process) a todas las partes. La investigación será realizada de manera confidencial hasta el punto que la confidencialidad es posible. La Compañía documentará y estará al tanto del proceso de la investigación. La Compañía hará una determinación razonable, después de revisar todas las pruebas, sobre si es que conducta inapropiada ocurrió. La investigación se completará en forma oportuna y el empleado que presento la queja recibirá una respuesta oportuna. Si se determina que conducta inapropiada sucedió, se tomará las medidas correctivas apropiadas. Se tomará medidas disciplinarias, hasta e incluyendo la descarga de empleo, contra cualquier empleado que se determine haber participado en conducta prohibida por esta política.

Ningún empleado será sujeto a alguna forma de represalia por reportar honestamente y en buena fe una violación de esta política, o por participar en una investigación conducida de acuerdo a esta política.

HOSTIGAMIENTO O ACOSO POR MEDIO DE NO-EMPLEADOS

Adicionalmente, la Compañía tomará todos los pasos razonables para prevenir o eliminar el acoso sexual por parte de no-empleados incluyendo clientes, vendedores y suministradores que tengan contacto de trabajo con nuestros empleados.

RECONOCIMIENTO DE LA POLÍTICA DE RELACIONES DE EMPLEADOS

Yo he recibido y leído una copia de la Política de Relaciones de Empleados de la Compañía, incluyendo las políticas en contra de la discriminación, la represalia y el hostigamiento, incluyendo el acoso sexual, y entiendo completamente mis obligaciones y responsabilidades bajo esta política.

Firma: _____ Fecha: _____

Testigo: _____ Fecha: _____

POSSESSION AND USE OF DRUGS AND ALCOHOL

The Company recognizes the employees' right to privacy; however, the Company is committed to providing a safe, efficient and productive work environment for all employees. In keeping with this commitment, employees and job applicants may be asked to undergo a drug/alcohol screening to determine the use of such substances. To further promote this goal, the Company will not tolerate the possession of or use of alcohol or drugs while on the Company's premises or time. Employees are required to report to work in appropriate mental and physical condition to perform their jobs in a satisfactory manner.

While on the Company's premises and while conducting Company related business activities which may occur off the Company's premises, no employee shall use, possess, distribute, sell or be under the influence of alcohol or drugs (except for the use of physician prescribed medication when the employee's supervisor has been advised of such prescribed use). The legal use of prescribed drugs is permitted on the job only if it does not impair an employee's ability to perform the essential functions of the job effectively and in a safe manner that does not endanger other individuals in the workplace.

Drug and alcohol tests may be conducted in any of the following situations:

POST OFFER: As a pre-qualification to assuming any position, prospective employees may be required to submit to a drug/alcohol test.

POST-ACCIDENT: Any current employee who is involved in an incident or accident while on duty, whether on or off the Company's premises, may be required to undergo a drug/alcohol test.

FITNESS FOR DUTY: This test may be required if significant and observable changes in an employee's performance, appearance, behavior, speech, etc. provides reasonable suspicion and probable cause to believe that the employee is under the influence of drugs or alcohol while on the Company's time or premises which could result in injury to the employee or fellow employees, or subject the Company to legal exposure, or public embarrassment, the Company may require the employee to submit to a drug test.

"Probable cause" shall exist when an employee's ability to perform their job duties is impaired. "Impaired" means that the employee's motor senses or judgment are or may be affected. Probable cause shall also exist if an employee is involved in either a job-related accident or violation of a safety rule or standard, which did or could have resulted in serious injury or property damage.

Positive results will result in discipline, including discharge. The employee may be offered the opportunity to participate in a rehabilitation program.

**POSSESSION AND USE OF DRUGS AND ALCOHOL
ACKNOWLEDGMENT FORM**

I have read and received a copy of the Company's Possession and Use of Drugs and Alcohol policy and fully understand my obligations and responsibilities as outlined therein.

Signed: _____ Date: _____

Witness: _____ Date: _____

MEAL AND REST PERIOD POLICY

Employees that are scheduled to work more than five (5) hours must take a thirty (30) minute uninterrupted meal period, off the clock, no later than the end of the fifth hour of work. Employees are entitled to be relieved of all their duties and free to take care of personal matters during that time. Employees that have a six (6) hour shift may voluntarily waive the meal period if they execute a Six Hour Shift Waiver Form. Please see the Human Resource Department.

The Company provides a paid ten (10) minute rest period for every four (4) hours of work or major fraction thereof. An employee who works between three and a half (3 1/2) to six (6) hours is entitled to one (1) ten minute break, an employee who works over six (6) hours is entitled to a second ten minute break. An employee that works less than three and a half (3 1/2) hours is not entitled to receive a paid ten (10) minute rest period. Please check with your supervisor for the appropriate time to take meal and rest breaks.

Meal periods and rest periods may not be waived to leave early nor may they be consolidated for a longer break or meal period.

It is against Company policy for any employee to perform work during meal or rest periods. It is against Company policy to return to work before the end of a 30 minute meal period or ten minute rest break. It is also against Company policy for employees to work “off the clock,” that is, perform work without recording it as time worked on their timesheets.

Employees working more than ten (10) hours are entitled to a second meal period before end of the tenth hour of work, unless the employee voluntarily executes a Twelve Hour Shift Waiver Agreement and has taken the first meal period.

The undersigned acknowledges that he or she has read and understands the foregoing Meal and Rest Period Policy.

Employee Signature

Date

SICK LEAVE POLICY

Full-Time and Part-Time Employees

Employees who have worked at least thirty (30) days within a year are entitled to paid sick leave under the Healthy Workplaces, Healthy Families Act. Eligible employees will be granted three (3) days or twenty-four (24) hours of paid sick time benefits up front on January 1 of every year. A lump sum of three (3) days or twenty-four (24) hours of paid sick leave will appear on the employees' pay stubs. There is no carryover of unused time from year to year, and employees start fresh each year.

The minimum increment of use of paid sick leave is two (2) hours.

Use of Sick Time (All Employees)

Employees are entitled to use paid sick time starting on their 90th day of employment for the following reasons: (1) diagnosis, care or treatment of an existing health condition of the employee or a covered family member of the employee, (2) preventative care for the employee or a covered family member of the employee, and (3) for court dates, medical treatment, or counseling or safety planning when the employee is a victim of domestic violence, sexual assault or stalking. Covered family members include the employee's parent, child, spouse, registered domestic partner, grandparent, grandchild, sibling, and spouse's or registered domestic partner's parent.

If the need for paid sick leave is foreseeable, employees must provide advance oral or written notification to their supervisor or the Office Manager. Advance notice requires notification at least one (1) hour before their scheduled starting time. If the need for paid sick leave is not foreseeable, employees must provide notice to their supervisor or Office Manager as soon as practical. An employee's use of paid sick time may run concurrently with other leaves under state or federal law.

Unused sick time accrued will not be made payable to employees upon leaving the service of the Company, regardless of the reason for separation. Employees who are rehired within one year of separation from employment may be eligible for reinstatement of previously accrued paid sick time. Payment for sick days is not considered as time worked in the computation of overtime.

Employees will generally be required to submit a certification from their treating licensed medical care practitioner upon returning to work after an absence of three (3) consecutive days or more. Employees will be required to provide a release from their medical care practitioner to return to work if the employee is hospitalized for twenty-four (24) hours or more or for outpatient surgery.

Subject to the conditions that they be employed by the Company in California for thirty (30) or more days within a year from the commencement of employment and have been employed by the Company for at least ninety (90) days from the date of hire, seasonal and temporary employees will be permitted to use paid sick leave which they will accrue based on the number of hours worked at the rate of one (1) hour for every thirty (30) hours worked.

EMPLOYEE STATEMENT

1. I acknowledge receipt of my copy of the Company Employee Handbook. I have read and understand its contents, including the Company policies and rules governing my conduct, wages and working conditions as an employee. I have had the opportunity to ask questions about the Company's policies and rules. I agree to abide by these policies and rules during my employment and understand the consequences if I do not.

2. I understand that this Employee Handbook, and the Company's policies, rules and benefits may be changed at any time at the sole discretion of the President. I further understand that my employment is "at will", that either I or the Company may terminate the employment relationship at any time, that I may be disciplined, including demoted any time, at the discretion of the Company, and that the Employee Handbook is not a contract of employment. I further acknowledge that there are no express or implied agreements which contradict this provision of at-will employment, that the only person empowered to modify or alter this provision of at-will employment is the Company President, and that any agreement to modify the at-will status of my employment must be in writing and fully executed by the President and myself. I further understand that this acknowledgment supersedes all previous agreements, written or oral.

3. I will observe strict secrecy as to the accounts of all customers and as to all the transactions of the Company of whatever description with its customers, Company employees and officers or stockholders and I will not divulge any of said matters, nor the status of any of said accounts, nor the number of shares held by any person or persons, nor the nature of any interest that any person or customer may have in the affairs of the Company and I will not divulge any of the credit information of any person, company or corporation which I may acquire as an employee or use any information of whatsoever kind or character which I may receive as an employee for any purpose other than for the advancement of the interests of the Company and I will at no time divulge any such information to any person not entitled thereto.

4. I further promise that I will honestly and faithfully conduct myself, and duly and diligently perform all the duties assigned to me while in the employ of the Company, and I will truly and faithfully account for and deliver to the Company all moneys, securities and other property belonging to the Company which I may receive for, from or on account of the Company, and that upon termination of my employment, I will at once deliver to the Company, all books, documents, money, securities or other property belonging to the Company or for which the Company is liable to others, which shall be, or which ought to be, in my charge of custody, and I will in all other respects honestly and faithfully perform all my duties as an employee of the Company.

5. I shall be bound by all the rules and regulations of the Company now in force, and by all such other rules and regulations as may be hereinafter called to my notice and I will faithfully observe and abide by the same.

6. I agree that while employed by the Company, I will accept no other employment, either full or part-time, for compensation without prior written consent of the Company.

Dated: _____

Employee's Signature

Please return the Employee Statement when you have completed reading this booklet.

UNEARNED VACATION AGREEMENT

Your vacation time of _____(____) days which you are taking from _____ through _____, of which _____(____) days are unearned, will be paid to you in your following paycheck. However, should your employment with the Company terminate for any reason before it becomes earned pursuant to our vacation policy, that portion which is unearned will be deducted from your final paycheck.

I hereby have read the foregoing Unearned Vacation Agreement and understand the same and do hereby authorize the Company to deduct all unearned vacation from my final paycheck.

Dated: _____

Employee's Signature

Dated: _____

Company Signature

ACKNOWLEDGMENT OF RECEIPT

I, _____, acknowledge that I have received
(print name)

copies of the following documents:

Initials

_____ Labor Code Section 2810.5 for New Hires

_____ Federal Form W-4

_____ State Form DE-4 Employees Withholding Allowance Certificate

_____ Form I-9

_____ Form I-9 Instructions

_____ Workers' Compensation Benefits Statement and Physician Election Form
(English and Spanish)

_____ State Disability Insurance Booklet (DE-2515)

_____ EDD For Your Benefit Booklet (DE-2320)

_____ California Paid Family Leave (DE-2511)
(English and Spanish)

_____ Department of Fair Employment and Housing Sexual Harassment Pamphlet
(English and Spanish) (DFEH-185 and DFEH-185s)

_____ Company's Employee Relations Policy with Acknowledgment

_____ Sick Leave Policy

Date: _____

Employee Signature