Reset Form

CALIFORNIA STATE UNIVERSITY, FRESNO FOUNDATION

STUDENT/PART-TIME/TEMPORARY EMPLOYEE INFORMATION SHEET

PLEASE CHECK THE CORRECT BOX(ES):

☐ **NEW HIRE**
☐ **RE-HIRE**

☐ **PART-TIME**
- ☐ Fresno State Faculty
- ☐ Fresno State Staff
- ☐ Non-Fresno State Employee

☐ **STUDENT AT FRESNO STATE**
_____ #of units enrolled for:
☐ Fall ☐ Spring ☐ Summer

☐ **CHANGE**
- ☐ Address
- ☐ Cost Center
- ☐ Pay Increase
- ☐ Other: _____

TO BE COMPLETED BY EMPLOYEE

Name:	Social Security Number:

Mailing Address: _____
Street Apt. # City State Zip Code

Phone Number: _____

Fresno State Email Address: _____@mail.fresnostate.edu

☐ Married ☐ Single	☐ Male ☐ Female	Date of Birth:	Check Route: ☐ Bookstore ☐ Foundation ☐ US Mail

Have you worked or are you currently working for the Association, Ag Foundation, Fresno State Programs for Children or Fresno State?

☐ Yes ☐ No If yes, Last Day Worked: _____ Department: _____

EMERGENCY CONTACT INFORMATION

Name: _____ Relationship: _____ Phone: _____

CALIFORNIA STATE UNIVERSITY, FRESNO FOUNDATION 401K PLAN

I wish to contribute to the Foundation 401K plan ☐ Yes, I will complete the enrollment and beneficiary forms. ☐ No, I decline to contribute.

ACKNOWLEDGEMENTS

I have received and acknowledge the following forms as part of the new hire packet:

- ☐ Nature of Employment Agreement
- ☐ Interim Vaccine Policy
- ☐ AB 469 Rate and Payday Notification
- ☐ Drug Free Workplace Policy
- ☐ Injury and Illness Prevention Program
- ☐ Employee Handbook (available on www.Auxiliary.FresnoState.edu)
- ☐ W4 and DE 4 Form
- ☐ I-9 Employment Eligibility Form

Dated: _____ Employee Signature: _____

TO BE COMPLETED BY SUPERVISOR

Cost Center/Obj. Code/Subsidiary:	**Date of Hire or Re-hire:**	**Mail Stop:**
Pay Rate or Flat Rate Amount:	**Position Title:**	

Is it likely that this position would have contact with minors (individuals under the age of 18)?
☐ **Yes** ☐ **No**

Confidential Data Access? ☐ **Yes** ☐ **No**	**Is driving a requirement for this position?** ☐ **Yes** ☐ **No**	**Supervisory Responsibility?** ☐ **Yes** ☐ **No**

Nepotism: "Related employees are not permitted to work in job positions in which a conflict of interest could arise or in a direct supervisory relationship." To my knowledge, this hire does not violate the Foundation Nepotism policy. _____Employee Initials _____ Supervisor Initials

PAY INCREASE *Please attach justification and AB 469

Reason for Increase:

Current Hourly Rate:	New Hourly Rate:	Effective Date:

APPROVALS REQUIRED

Employee Signature	Date
Supervisor Signature	Date
Program/Project Director Signature	Date
Post Award Analyst Signature	Date

OFFICE USE ONLY

Aux ID:	Date:	Entered by:	Paid Sick Leave:	Date:	Reviewed by:	Date:

CALIFORNIA STATE UNIVERSITY, FRESNO FOUNDATION

Hiring Checklist

Name:_____ Date of Hire:_____

Dept/Project:_____ Cost Center:_____

To be returned to Human Resources at Time of Hire:

. . . . . Employee Information Sheet
. . . . . Application
. . . . . Nature of Employment Acknowledgment
. . . . . Interim Vaccine Policy
. . . . . Emergency Contact Information
. . . . . AB 469 Rate and Payday Notification
. . . . . Child Abuse and Neglect Reporting Act (CANRA) Acknowledgment
. . . . . Drug Free Workplace Acknowledgment
. . . . . IIPP Acknowledgement
. . . . . Employee Handbook Acknowledgment
. . . . . Federal W-4 & State DE-4 Tax Forms
. . . . . *I-9 Employment Eligibility Form & Appropriate Identification
. . . . . Hartford 401K Enrollment/Change Form & Beneficiary Designation Form (if elected)

Additional Forms Available to Employees by Request:

. . . . . Employee Handbook (available on www.Auxiliary.FresnoState.edu)
. . . . . Sexual Harassment Brochure
. . . . . Employee Assistance & Development Brochure (EA&D)
. . . . . Workers' Compensation Informational Brochures
. . . . . Workplace Violence Guide
. . . . . State Disability Insurance Brochure
. . . . . Paid Family Leave Insurance Brochure

_____ _____
Employee Signature Date

_____ _____
Supervisor Signature Date

*Employee **CANNOT** begin work until I-9 form has been verified by HR personnel.

Reset Form

California State University, Fresno Auxiliary Corporations

2771 E. Shaw Avenue, Fresno, CA 93710 · www.auxiliary.com · Fax: (559) 278-0988 · HRAUX@LISTSERV.csufresno.edu

EMPLOYMENT APPLICATION FOR STUDENT/PART-TIME/TEMPORARY POSITIONS

Please Print Date: _____

Name: _____
(Last) *(First)* *(MI)*

Address: _____
(Number & Street) *(City)* *(State)* *(Zip)*

Telephone: _____ _____ _____
(Home) *(Work)* *(Cell)*

Email: _____

Employment Desired

Position applying for: _____ Department: _____

What days and hours are you available for work? _____

Are you available for work on weekends? ☐ Yes ☐ No

Would you be available for overtime, if necessary? ☐ Yes ☐ No

If hired, on what day can you start work? _____

Education, Training and Experience

School	Name and Address	No. of years Completed	Did you Graduate?	Degree Or Diploma
High School	Name Address City State Zip	____	☐ Yes ☐ No	
College/ University	Name Address City State Zip	____	☐ Yes ☐ No	
Vocational/ Business	Name Address City State Zip	____	☐ Yes ☐ No	
Other	Name Address City State Zip	____	☐ Yes ☐ No	

Please provide the following information and indicate the skills you possess **only** if they are a requirement of the position for which you are applying:

Driver's License Number: _____ State: _____ Class: _____

Languages you speak, read or write fluently in addition to English: _____

Do you have any other experience, training, qualifications or skills which you feel make you especially suited for work at California State University, Fresno Auxiliary Corporations? ☐ Yes ☐ No

If so, please explain: _____

Reset Form

Employment History

List below all present and past employment starting with your most recent employer. Account for all periods of unemployment. You must complete this section even if attaching a resume.

Name of Employer	*Dates of Employment:* *From* *To*
Type of Business	*Your Supervisor's Name*
Street Address	*Telephone No.*
City *State* *Zip*	*Your Reason for Leaving:*
Your Position and Duties:	*May we contact this employer for a reference?* ☐ Yes ☐ No

Name of Employer	*Dates of Employment:* *From* *To*
Type of Business	*Your Supervisor's Name*
Street Address	*Telephone No.*
City *State* *Zip*	*Your Reason for Leaving:*
Your Position and Duties:	*May we contact this employer for a reference?* ☐ Yes ☐ No

Name of Employer	*Dates of Employment:* *From* *To*
Type of Business	*Your Supervisor's Name*
Street Address	*Telephone No.*
City *State* *Zip*	*Your Reason for Leaving:*
Your Position and Duties:	*May we contact this employer for a reference?* ☐ Yes ☐ No

Name of Employer	*Dates of Employment:* *From* *To*
Type of Business	*Your Supervisor's Name*
Street Address	*Telephone No.*
City *State* *Zip*	*Your Reason for Leaving:*
Your Position and Duties:	*May we contact this employer for a reference?* ☐ Yes ☐ No

Reset Form

Personal Information

Have you ever applied to or worked for California State University, Fresno Auxiliary Corporations (which include the Association, the Agricultural Foundation, and the Foundation) before? ☐ Yes ☐ No
If yes, for which corporation and when? _____

Do you have friends or relatives working for California State University, Fresno Auxiliary Corporations? ☐ Yes ☐ No
If yes, state name, relationship and organization:

_____
Name *Relationship* *Organization*

If hired, would you have a reliable means of transportation to and from work? ☐ Yes ☐ No

If hired, can you provide evidence of your legal right to work in the United States? ☐ Yes ☐ No

Are you able to perform the essential functions of the job for which you are applying, either with or without reasonable accommodation? ☐ Yes ☐ No

If no, describe the functions that cannot be performed: _____.
(Note: We comply with the ADA and consider reasonable accommodation measures that may be necessary for eligible applicants/employees to perform essential functions. Hire may be subject to passing a medical examination, and to skill and agility tests.)

Are you currently employed? ☐ Yes ☐ No

If so, may we contact your current employer? ☐ Yes ☐ No

Please Read Carefully, Initial Each Paragraph and Sign Below

_____ I hereby certify that I have not knowingly withheld any information that might adversely affect my chances for employment and that the answers given by me are true and correct to the best of my knowledge. I further certify that I, the undersigned applicant, have personally completed this application. I understand that any omission or misstatement of material fact on this application or on any document used to secure employment shall be grounds for rejection of this application or for immediate discharge if I am employed, regardless of the time elapsed before discovery.

_____ I hereby authorize the company to thoroughly investigate my references, work record, education and other matters related to my suitability for employment and, further, authorize the references I have listed to disclose to the company any and all letters, reports and other information related to my work records, without giving me prior notice of such disclosure. In addition, I hereby release the company, my former employers and all other persons, corporations, partnerships and associations from any and all claims, demands or liabilities arising out of or in any way related to such investigation or disclosure.

_____ I understand that nothing contained in the application, or conveyed during any interview which may be granted or during my employment, if hired, is intended to create an employment contract between me and the company. In addition, I understand and agree that if I am employed, my employment is for no definite or determinable period and may be terminated at any time, with or without prior notice, at the option of either myself or the company, and that no promises or representations contrary to the foregoing are binding on the company unless made in writing and signed by me and the company's designated representative.

_____ _____
Date Applicant's Signature

Reset Form

FRESNO STATE

Auxiliary Services

STUDENT CLASS SCHEDULE

Name: _____

Address: _____

Cell Phone: _____

Home Phone: _____

Email Address: _____

Please place an "X" in each box during the time of your class.

Semester: _____

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
8:00 a.m.	☐	☐	☐	☐	☐	☐	☐
9:00 a.m.	☐	☐	☐	☐	☐	☐	☐
10:00 a.m.	☐	☐	☐	☐	☐	☐	☐
11:00 a.m.	☐	☐	☐	☐	☐	☐	☐
12:00 p.m.	☐	☐	☐	☐	☐	☐	☐
1:00 p.m.	☐	☐	☐	☐	☐	☐	☐
2:00 p.m.	☐	☐	☐	☐	☐	☐	☐
3:00 p.m.	☐	☐	☐	☐	☐	☐	☐
4:00 p.m.	☐	☐	☐	☐	☐	☐	☐
5:00 p.m.	☐	☐	☐	☐	☐	☐	☐
6:00 p.m.	☐	☐	☐	☐	☐	☐	☐
7:00 p.m.	☐	☐	☐	☐	☐	☐	☐
8:00 p.m.	☐	☐	☐	☐	☐	☐	☐
9:00 p.m.	☐	☐	☐	☐	☐	☐	☐

Reset Form

Equal Employment Opportunity Data

To be completed by applicant:

_____
Application Date

Completion of this form is entirely voluntary, and all information will remain confidential and will not affect your application for employment. We are required by law to collect this information for equal opportunity employment purposes, and it will not become part of your personnel record if you are hired by this company.

Name: _____

Position Applied for: _____ Department: _____

Gender: ☐ Male ☐ Female

Race/Ethnicity:
- ☐ American Indian/Alaskan Native
- ☐ Asian/Pacific Islander
- ☐ Black
- ☐ Hispanic
- ☐ White

Method of referral for employment at California State University, Fresno Auxiliary Corporations:

- ☐ Fresno State employee
- ☐ Newspaper advertisement
- ☐ Internet
- ☐ Friend/Relative
- ☐ Fresno State Auxiliary Corporations employee
- ☐ Auxiliary Job Announcement
- ☐ Employment Agency
- ☐ Other: _____

Government contractors must take affirmative action to employ and advance certain qualified individuals subject to the Rehabilitation Act of 1973 and the Vietnam Era Veterans Readjustment Act of 1974. Completion of the following information is voluntary, and will assist us in proper placement and reasonable accommodation. If you wish to be identified as qualifying for such placement or accommodation, please check where applicable:

- ☐ Vietnam Era Veteran
- ☐ Disabled Veteran
- ☐ Other Veteran
- ☐ Individual with a Disability

To be completed by employer:

EEO-1 Category:
- ☐ 1. Officials and managers
- ☐ 2. Professionals
- ☐ 3. Technicians
- ☐ 4. Sales
- ☐ 5. Office and clerical
- ☐ 6. Crafts – skilled
- ☐ 7. Operatives – semi-skilled
- ☐ 8. Laborers – unskilled
- ☐ 9. Service workers

Employer information completed by:

_____ _____
Name *Date*

CALIFORNIA STATE UNIVERSITY, FRESNO FOUNDATION

NATURE OF EMPLOYMENT

The relationship between employees and the California State University, Fresno Foundation (Foundation) is for an unspecified term and is considered employment at-will. No manager, supervisor or employee of the Foundation has authority to enter into any agreement for employment for any specified period of time or to make any agreement for employment other than at-will. Only the Executive Director has the authority to make any such agreement and then only in writing, signed by the Executive Director and indicating it is intended as a modification of a particular employee's at-will status. Consequently, the employment relationship with any employee can be terminated at will, either by the employee or the Foundation, with or without cause or advance notice. The Foundation can also demote and change pay and duties of any employee at-will.

All employees should be aware that the Foundation is not governed by collective bargaining. Although some benefits and policies may be the same or similar to those of the University, the Foundation has developed its own policies and procedures under California law, the California Code of Regulations, the Education Code, and under directives and policies by the Trustees and the Chancellor of The California State University system. The Foundation is a private employer under the Internal Revenue Code and is not a State agency.

All student employees should be aware that employment with the Foundation is for a maximum of twenty (20) hours per week during the academic year. If a Foundation student employee were to be concurrently employed through California State University, Fresno, the employee will work a maximum of twenty (20) hours per week, combined.

Any questions should be addressed to the Foundation Human Resources Department or the Executive Director for clarification. University employees may not be familiar with the policies and procedures of the Foundation and may not be able to provide accurate information.

Acknowledgment:

I have entered into my employment relationship with the Foundation voluntarily and acknowledge that there is no specified length of employment. I understand that I or the Foundation can terminate the relationship at-will, with or without notice or cause, at any time.

_____

Employee's Name (Printed)

_____ _____

Employee's Signature Date

CALIFORNIA STATE UNIVERSITY, FRESNO FOUNDATION

Compliance with CSU Interim Vaccine Policy

In accordance with CSU Interim Vaccine Policy, every auxiliary employee is required to be fully vaccinated against the COVID-19 virus and to complete the COVID-19 vaccine self-certification form through the MyFresnoState portal in the Employee Self Service section.

As part of the self-certification processes, the following certification options are available:

- Declaration of current COVID-19 vaccination status (with an Approved Vaccine, the last required dose of which was administered at least 14 calendar days prior to the date of Certification);
- Declaration of Medical Exemption;
- Declaration of Religious Exemption; or
- Declaration that the individual does not plan to access Campus/Programs, and that if their plans change, they will submit a revised Certification in advance of any such access.

Each certification includes an attestation by the employee that the information provided is accurate and truthful.

Additionally, if an employee is not fully vaccinated based on an approved exemption, they will be required to complete weekly mandatory COVID-19 testing. This testing is conducted on-campus by a third party vendor and to be done during work hours.

The California State University and Fresno State is committed to safeguarding the health and well-being of our students, faculty, staff, administrators, and the communities we serve, as well as maintaining higher education access and attainment for our students.

Failure to complete the mandatory self-certification within the first 14 days of your hire date and/or mandatory weekly testing will result in separation of your at-will employment.

Acknowledgment:

_____
Employee's Name (Printed)

_____ _____
Employee's Signature Date

Reset Form

CALIFORNIA STATE UNIVERSITY, FRESNO
AUXILIARY CORPORATIONS

EMPLOYEE EMERGENCY INFORMATION

Please complete the following emergency information (please print):

Employee Name _____ Phone _____

Address _____ Cell _____

City _____ Zip _____

In case of emergency, notify the following:

Name _____ Relationship _____

Address _____ Phone _____

City _____ Zip _____ Work _____

PRE-DESIGNATE PHYSICIAN FOR WORK RELATED INJURY

Please read carefully: This information pertains to work-related injury or illness:

You are entitled to be treated by your own personal physician if the pre-designation form is completed and returned to the Auxiliary Human Resources Office prior to any work-related injury. If you do not pre-designate a physician and need medical treatment for a work-related injury or illness, you will be referred to the organization's approved physician.

Please complete below:

☐ I elect to be treated by the organizations' approved work physician

☐ I elect to be treated by my own physician (Please list physician information below)

_____ _____
Physician Name Phone

_____
Address City Zip Code

Employee Signature _____ Date _____

Reset Form

Notice and Acknowledgement of Pay Rate and Payday
Under Section 2810.5 of the California Labor Code
Notice for Hourly Rate Non-Exempt Employees

Employee Information	
Name:	Start Date:

Employee Rate of Pay Per Hour		
Straight Time Rate:	Time & One Half Rate:	Double Time Rate:

Employer & Worker's Compensation Information	
Employer: California State University, Fresno Foundation 2771 E. Shaw Avenue Fresno, CA 93710 Phone: (559) 278-0865 Mailing Address (if different): N/A Doing Business As (DBA) Name(s): N/A	Workers' Compensation Insurance Carrier (name, address, phone): ICW Group P.O. Box 85563 San Diego, CA 92186 Toll Free Phone: 800-877-1111 Direct Phone: 858-350-2400

Wage Information	
Notice Given: ☐ At hiring ☒ Before a change in pay rate(s), allowances claimed or payday **Allowances taken:** ☒ None	**Pay is:** ☐ Weekly ☐ Bi-weekly ☒ Semi-monthly ☐ Other **Regular Pay Dates:** 7th and 22nd

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 (excluding Additional Employment employees).

☐ 4. The employee is exempt from paid sick leave protection by Labor Code §245.5. (State exemption and specific subsection for exemption)

Employee Acknowledgment

On this day I have been notified of my pay rate, overtime rate, allowances, designated pay day, and my employer's information on the date given below.

_____ _____
Employee Name (Printed) Date

_____ _____
Employee Signature Preparer's Name and Title

STATEMENT ACKNOWLEDGING REQUIREMENT TO REPORT CHILD ABUSE AND NEGLECT [*USE FOR LIMITED REPORTERS ONLY*]

INSTRUCTION FOR HUMAN RESOURCES: Provide this form, as well as Attachments A and B of Executive Order 1083 Revised July 21, 2017, to employees who are identified as Limited Reporters*. Retain the completed form in the employee's official personnel file.

**Exception:* Non-Management Personnel Plan employees hired prior to January 1, 1985

California law **requires** certain people, known as "Mandated Reporters," to report known or suspected child abuse or neglect. You have been identified as a certain type of Mandated Reporter: a Limited Reporter under Penal Code § 11165.7(a)(41). As a Mandated Reporter, you are required by the law to sign this statement acknowledging your legal reporting obligations.

A copy of the relevant provisions of the law explaining the definition of "Mandated Reporter" (Penal Code § 11165.7), the reporting obligations (Penal Code § 11166), penalty for failure to report abuse or impeding report (Penal Code § 11166.01), the contents of the reports, and the confidentiality of the Mandated Reporter's identity (Penal Code § 11167) is attached.

Online training is available to you at **https://ds.calstate.edu/?svc=skillsoft** (under keyword search "Mandated Reporter").

While it is not required, we strongly encourage you to take the training.

WHEN REPORTING ABUSE IS REQUIRED

As a Limited Reporter, whenever in your professional capacity or within the scope of your employment you have knowledge of or observe a person under the age of 18 years whom you know or reasonably suspect has been the victim of child abuse or neglect ***on CSU premises or at an official activity of, or program conducted by, the CSU,*** you must report the suspected incident (Penal Code §§ 11166(a) and 11165.7(a)(41)).

PROCEDURE FOR REPORTING

To make a report, you **must** do the following:

- ***Immediately, or as soon as practically possible,*** contact by phone one of the following: police or sheriff's department (including campus police but not including a school district police or security department); a county probation department (if designated by the county to receive mandated reports); or the county welfare department (Child Protective Services or CPS).

- ***Within 36 hours of receiving the information concerning the incident:*** complete Form SS 8572 (available online at http://ag.ca.gov/childabuse/pdf/ss_8572.pdf) per the instructions (available online at http://ag.ca.gov/childabuse/pdf/8572_instruct.pdf); and send, fax or electronically transmit it to the agency that was contacted by phone (Penal Code § 11166(a)).

Names and contact information for agencies that can accept reports are available online at the following websites:

California State University Police Departments (by campus):
http://calstate.edu/strategicinitiatives/UPD/contacts.shtml

Child Protective Services (by county):
http://www.hwcws.cahwnet.gov/countyinfo/county_contacts/hotline_numbers.asp

For Sheriffs' Departments (by county):
http://www.calsheriffs.org/sheriffs-offices.html

Note: Reporting to a supervisor, a coworker, or other person is not a substitute for making a mandated report to one of the agencies listed above.

ABUSE AND NEGLECT THAT MUST BE REPORTED

Physical abuse, meaning physical injury other than by accidental means inflicted on a child (Penal Code § 11165.6).

Sexual assault, including sex acts with a child, intentional masturbation in the presence of a child, child molestation, and lewd or lascivious acts with a child under 14 years of age or with a child under 16 years of age if the other person is at least ten years older than the child (Penal Code § 11165.1(a)(b)).

Sexual exploitation, including acts relating to child pornography, child prostitution, or performances involving obscene sexual conduct by a child (Penal Code § 11165.1(c)).

Statutory rape involving sexual intercourse between a child under 16 years of age and a person 21 years of age or older, which is also a form of "sexual assault" (Penal Code § 11165.1(a)).

Neglect, meaning the negligent treatment or maltreatment of a child by a parent, guardian or caretaker under circumstances indicating harm or threatened harm to the child's health or welfare (Penal Code § 11165.2).

Willful harming or injuring or endangering a child, meaning a situation in which any person inflicts, or willfully causes or permits a child to suffer, unjustifiable physical pain or mental suffering, or causes or permits a child to be placed in a situation in which the child or child's health is endangered (Penal Code § 11165.3).

Unlawful corporal punishment, meaning a situation in which any person willfully inflicts upon a child cruel or inhuman corporal punishment or a physical injury (Penal Code § 11165.4).

WHAT IS NOT CHILD ABUSE OR NEGLECT?

The law does **not** consider the following child abuse or neglect for reporting purposes:

- Injuries caused by two children fighting during a mutual altercation (Penal Code § 11165.6)
- An injury caused by reasonable and necessary force used by a peace officer acting within the course and scope of his or her employment (Penal Code § 11165.6)

- Reasonable and necessary force used by public school officials to quell a disturbance threatening physical injury to person or damage to property, for self-defense, or to obtain possession of weapons or other dangerous objects under a child's control (Penal Code § 11165.4)
- Corporal punishment, unless it is cruel or inhumane or willfully inflicts a physical injury (Penal Code § 11165.4)
- Not receiving medical treatment for religious reasons (Penal Code § 11165.2(b))
- Acts performed for a valid medical purpose (Penal Code § 11165.1(b)(3))
- An informed and appropriate medical decision made by a parent or parent, guardian or caretaker after consultation with a physician who has examined the child (Penal Code § 11165.2(b))

IMMUNITY AND CONFIDENTIALITY OF REPORTER

Mandated Reporters cannot be held civilly or criminally liable for their reports. Instead, they enjoy immunity from prosecution for their reporting of suspected child abuse (Penal Code § 11172(a)). Both the identity of the person who reports and the report itself are confidential and disclosed only among appropriate agencies (Penal Code § 11167(d)).

PENALTY FOR FAILURE TO REPORT ABUSE OR IMPEDING REPORT

A Mandated Reporter who fails to make a required report of abuse, or any administrator or supervisor who impedes or inhibits a report, is guilty of a misdemeanor punishable by up to six months in jail, a fine of $1,000, or both (Penal Code Section 11166(c) and Section 11166.01(a)). Where the abuse results in death or great bodily injury, the Mandated Reporter who fails to make a required report or administrator or supervisor who impeded or inhibited the report is subject to punishment of up to one year in jail, a fine of $5,000, or both (Penal Code Section 11166.01(b)).

ACKNOWLEDGMENT

I acknowledge being provided with copies of Penal Code Sections 11165.7, 11166, 11166.01, and 11167. I acknowledge and understand my responsibility and legal obligation to report known or suspected child abuse or neglect in compliance with Penal Code Section 11166.

Employee's Name: _____ Dept.: _____

Signature: _____ Date: _____

STATEMENT ACKNOWLEDGING REQUIREMENT TO REPORT CHILD ABUSE AND NEGLECT [*USE FOR GENERAL REPORTERS ONLY*]

California law **requires** certain people, known as "Mandated Reporters," to report known or suspected child abuse or neglect. You have been identified as a Mandated Reporter (General Reporter). As a General Reporter, you are required by the law to sign this statement acknowledging your legal reporting obligations.

A copy of the relevant provisions of the law explaining the definition of "Mandated Reporter" (Penal Code § 11165.7), the reporting obligations (Penal Code § 11166), penalty for failure to report abuse or impeding report (Penal Code § 11166.01), the contents of the reports, and the confidentiality of the Mandated Reporter's identity (Penal Code § 11167) is attached.

Online training is available to you at **https://ds.calstate.edu/?svc=skillsoft** (under keyword search "Mandated Reporter").

While it is not required, we strongly encourage you to take the training.

WHEN REPORTING ABUSE IS REQUIRED

As a Mandated Reporter (General Reporter), whenever in your professional capacity or within the scope of your employment you have knowledge of or observe a person under the age of 18 years whom you know or reasonably suspect has been the victim of child abuse or neglect, you must report the suspected incident, ***no matter where it occurred*** (Penal Code §§ 11166(a)).

PROCEDURE FOR REPORTING

To make a report, you **must** do the following:

- ***Immediately, or as soon as practically possible,*** contact by phone one of the following: police or sheriff's department (including campus police, but not including a school district police or security department); a county probation department (if designated by the county to receive mandated reports); or the county welfare department (Child Protective Services or CPS).

- ***Within 36 hours of receiving the information concerning the incident:*** complete Form SS 8572 (available online at http://ag.ca.gov/childabuse/pdf/ss_8572.pdf) per the instructions (available online at http://ag.ca.gov/childabuse/pdf/8572_instruct.pdf); and send, fax or electronically transmit it to the agency that was contacted by phone (Penal Code § 11166(a)).

Names and contact information for agencies that can accept reports are available online at the following websites:

California State University Police Departments (by campus):
http://calstate.edu/strategicinitiatives/UPD/contacts.shtml

Child Protective Services (by county):
http://www.hwcws.cahwnet.gov/countyinfo/county_contacts/hotline_numbers.asp

For Sheriffs' Departments (by county):
http://www.calsheriffs.org/sheriffs-offices.html

Note: Reporting to a supervisor, a coworker, or other person is not a substitute for making a mandated report to one of the agencies listed above.

ABUSE AND NEGLECT THAT MUST BE REPORTED

Physical abuse, meaning physical injury other than by accidental means inflicted on a child (Penal Code § 11165.6).

Sexual assault, including sex acts with a child, intentional masturbation in the presence of a child, child molestation, and lewd or lascivious acts with a child under 14 years of age or with a child under 16 years of age if the other person is at least ten years older than the child (Penal Code § 11165.1(a)(b)).

Sexual exploitation, including acts relating to child pornography, child prostitution, or performances involving obscene sexual conduct by a child (Penal Code § 11165.1(c)).

Statutory rape involving sexual intercourse between a child under 16 years of age and a person 21 years of age or older, which is also a form of "sexual assault" (Penal Code § 11165.1(a)).

Neglect, meaning the negligent treatment or maltreatment of a child by a parent, guardian or caretaker under circumstances indicating harm or threatened harm to the child's health or welfare (Penal Code § 11165.2).

Willful harming or injuring or endangering a child meaning a situation in which any person inflicts, or willfully causes or permits a child to suffer unjustifiable physical pain or mental suffering, or causes or permits a child to be placed in a situation in which the child or child's health is endangered (Penal Code § 11165.3).

Unlawful corporal punishment, meaning a situation in which any person willfully inflicts upon a child cruel and inhuman corporal punishment or a physical injury (Penal Code § 11165.4).

WHAT IS NOT CHILD ABUSE OR NEGLECT?

The law does **not** consider the following child abuse or neglect for reporting purposes:

- Injuries caused by two children fighting during a mutual altercation (Penal Code § 11165.6)
- An injury caused by reasonable and necessary force used by a peace officer acting within the course and scope of his or her employment (Penal Code § 11165.6)

- Reasonable and necessary force used by public school officials to quell a disturbance threatening physical injury to person or damage to property, for self-defense, or to obtain possession of weapons or other dangerous objects under a child's control (Penal Code § 11165.4)
- Corporal punishment, unless it is cruel or inhumane or willfully inflicts a physical injury (Penal Code § 11165.4)
- Not receiving medical treatment for religious reasons (Penal Code § 11165.2(b))
- Acts performed for a valid medical purpose (Penal Code § 11165.1(b)(3))
- An informed and appropriate medical decision made by a parent, guardian or caretaker after consultation with a physician who has examined the child (Penal Code § 11165.2(b))

IMMUNITY AND CONFIDENTIALITY OF REPORTER

Mandated Reporters cannot be held civilly or criminally liable for their reports. Instead, they enjoy immunity from prosecution for their reporting of suspected child abuse (Penal Code § 11172(a)). Both the identity of the person who reports and the report itself are confidential and disclosed only among appropriate agencies (Penal Code § 11167(d)).

PENALTY FOR FAILURE TO REPORT ABUSE OR IMPEDING REPORT

A Mandated Reporter who fails to make a required report of abuse, or any administrator or supervisor who impedes or inhibits a report, is guilty of a misdemeanor punishable by up to six months in jail, a fine of $1,000, or both (Penal Code Section 11166(c) and Section 11166.01(a)). Where the abuse results in death or great bodily injury, the Mandated Reporter who fails to make a required report or administrator or supervisor who impeded or inhibited the report is subject to punishment of up to one year in jail, a fine of $5,000, or both (Penal Code Section 11166.01(b)).

ACKNOWLEDGMENT

I acknowledge being provided with copies of Penal Code Sections 11165.7, 11166, 11166.01, and 11167. I acknowledge and understand my responsibility and legal obligation to report known or suspected child abuse or neglect in compliance with Penal Code Section 11166.

Employee's Name:_____ Dept.: _____

Signature:_____ Date: _____

Reset Form

FRESNO STATE

Auxiliary Services

Agreement for Waiver of Meal Period

Employee Name: _____

Employee and Employer agree to the following regarding the Employee's meal period:

Initial appropriate paragraph(s):

_____ Employee's Initials
_____ Employer's Initials

The nature of the Employee's work prevents the Employee from being relieved of all duty during the Employee's meal period and that the Employee shall work an on-the-job meal period that shall be paid for by the Company.

And/or

_____ Employee's Initials
_____ Employer's Initials

The Employee's work shift for the day's work does not exceed six (6) hours. The employee waives any meal period on the work shift.

And/or

_____ Employee's Initials
_____ Employer's Initials

The Employee's work shift for the day is 10 hours or more (but does not exceed 12 hours). The employee waives the second meal break.

This agreement is freely and voluntarily entered into.

This agreement is valid during the following dates: from _____ to _____

Employee Signature _____ Date: _____

Company/Unit _____

Employer Signature _____ Date: _____

Employer Name (Print) _____

Drug Free Workplace Policy

PURPOSE

California State University, Fresno Foundation ("Foundation") is committed to providing a safe, healthy and productive work environment for all employees and other individuals in the workplace. Consistent with this commitment, and its obligations under applicable law, this policy establishes the Foundation's intent to provide an alcohol and drug-free environment and to encourage our employees to voluntarily seek help with any alcohol and drug-related problems.

STATEMENT OF POLICY

Any individual who conducts business for the Foundation, is applying for a position or is conducting business on the Foundation's premises is covered by this policy. Specifically, the policy applies to, but is not limited to, managers, supervisors, full-time, part-time, and temporary employees, independent contractors, visitors, volunteers, interns and applicants.

This policy is intended to apply whenever anyone is representing or conducting business for or on behalf of the Foundation. Employees are expected and required to report to work on time and in appropriate mental and physical condition for work. It is the Foundation's intent and obligation to provide a drug free, healthy, safe and secure work environment.

REGULATIONS and PROHIBITIONS

The Foundation prohibits the following:

- The unlawful possession, manufacture, distribution, dispensation, sale, transportation, offer to sell, promotion, purchase and/or use of drugs, alcohol*, or controlled substance at any Foundation worksite, at any Foundation sponsored/sanctioned activities and events, and while employees or other individuals as previously described perform Foundation-related business, regardless of the location. Employees and other individuals as previously described shall not report for work or work under the influence of any drug or alcohol or other substances that will impair work performance, alertness, coordination or response, or affect the safety and health of others.

    * On campus or Foundation worksite possession, distribution or use of alcohol is limited to certain approved events and locations covered by the guidelines of Fresno State's official Policy on Alcohol and Other Drugs.

Apart from said events, such possession, distribution or use of alcohol is strictly prohibited.

- Consistent with federal law and the provisions of the California Adult Use of Marijuana Act, Proposition 64, the Foundation strictly prohibits the use, consumption, possession, transfer, display, sale, or growth of cannabis, in any form, including but not limited to, smoking, oils, and edibles. This is true even if such use of cannabis is for medicinal purposes authorized and permitted under the California Compassionate Use Act, Proposition 215.
- Prescription and over-the-counter drugs are not prohibited when taken in standard dosage and/or according to a physician's prescription. Any employee taking prescribed or over-the-counter medications will be responsible for consulting the prescribing physician and/or pharmacist to ascertain whether the medication may interfere with safe performance of his/her job. If the use of a medication could compromise the safety of the employee, fellow employees or the public, it is the employee's responsibility to use appropriate personnel procedures (e.g., call in sick, use leave, request change of duty, notify supervisor, notify company doctor) to avoid unsafe workplace practices. The illegal or unauthorized use of prescription drugs is prohibited. It is a violation of the Foundation's policy to intentionally misuse and/or abuse prescription medications. Appropriate disciplinary action will be taken if job performance deterioration and/or other accidents occur.
- If, at any time, a Foundation representative has a reasonable belief that an employee is in possession, use, or distribution of alcohol and/or drugs in violation of this policy, the Foundation may notify law enforcement to fully investigate the matter and/or take further corrective action, including but not limited to termination.

Mandatory Obligation to Report Convictions

In accordance with the Drug-Free Workplace Act of 1988, any Foundation employee must, as a condition of employment, abide by the terms of the policy and report any conviction (including a plea of nolo contendere i.e. no contest) under a criminal drug statute violation occurring at any Foundation worksite or university or while elsewhere conducting Foundation or university business. Said conviction must be reported to the Auxiliary Human Resources Department within five (5) days.

As a condition of continued institutional grant or contract eligibility, and as a condition of employment under any federal and/or state contract or grant, employees must not only comply with this policy but also with the requirement of notifying the Auxiliary Human Resources Department within five (5) days of any conviction under a criminal drug statute where the criminal act upon which the conviction is based occurred while on Foundation worksite or elsewhere

conducting Foundation or university business, or upon property owned, operated or controlled by the university.

Within ten (10) days after receiving such notice, the Foundation is required to notify the federal and/or state grant or contract authority. Within thirty (30) days after receiving such notice, the Foundation may initiate appropriate disciplinary action against the employee, up to and including termination, or require the employee to participate satisfactorily in an approved drug abuse assistance or rehabilitation program.

Legal Sanctions under Federal and State Law
Federal and state laws establish severe penalties for any individual convicted of the manufacture, possession, distribution or use of controlled substances. These penalties, upon conviction, may range from a small fine and probation to imprisonment, or both.

For a detailed list of federal penalties related to controlled substances, please refer to the U.S. Department of Justice Drug Enforcement Administration website. For a detailed list of state penalties related to controlled substances, please refer to Health and Safety Code, sections 11350—11356.5 and sections 11377—11382.5.

The Foundation is required by federal law to take disciplinary action up to and including suspension or termination of employment for any individual convicted of a workplace drug offense.

Drug and Alcohol-Related Health Risks
The use and abuse of drugs and alcohol can have severe negative effects in behavior and physiology. Drugs and alcohol are chemicals, and by their very nature, cause reactions in the body. Possible effects from drug and alcohol use include, but are not limited to, convulsions, memory loss, psychosis, anxiety, delusions, hallucinations, sleep disorders, depression, liver and kidney damage, cardiac irregularities, hepatitis, neurological damage, and even death.
For additional resources that describe the health risks associated with the use of drugs and alcohol, please visit the following websites:

- www.drugabuse.gov/drugs-abuse
- www.dea.gov/druginfo/factsheets.shtml
- www.niaaa.nih.gov/alcohol-health/alcohols-effects-body
- www.rethinkingdrinking.niaaa.nih.gov

Resources, Education and Assistance

The Foundation recognizes drug and alcohol dependency as treatable conditions and offers its employees services from the Employee Assistance Program (EAP) for substance abuse and/or dependency problems. Employees are encouraged to seek assistance from drug and alcohol-related problems and may request leaves of absence for this purpose, in addition to using approved vacation or sick leave.

Information obtained regarding an employee during participation in EAP will be treated as confidential. Access to this information is limited to those who have a legitimate need to know in accordance with federal and state laws, and management policies.

- Foundation employees may obtain confidential consultation regarding substance abuse or other personal problems at no cost to the employee or member of his/her immediate family. A careful assessment of the situation will be made and alternatives will be offered that are both appropriate and affordable.
- Community agencies are also available to address drug and alcohol-related problems. Most of the various local drug treatment programs offer no-cost assessment and may be located on the Internet under “Drug Abuse & Addiction Information & Treatment Centers.”

Treatment for drug and alcohol-related problems may be covered by the employee’s benefit plan. However, the employee bears the ultimate financial responsibility for any recommended treatment.

Shared Responsibility

A safe and productive drug-free workplace is achieved through cooperation and shared responsibility. Both employees and supervisors have important roles to play. All employees are required to not work or be subject to duty while their ability to perform job duties is impaired due to on/or off-duty use of alcohol and/or drugs.

Supervisors are responsible for informing employees of the Foundation’s alcohol and drug-free workplace policy as well as documenting negative changes and/or problems in work performance.

Communication

This policy is included in the Foundation Employee Handbook and the Employee New Hire Packet. As a condition of employment, all employees are required to review, execute, and date an acknowledgment of having received a copy of said policy. The executed acknowledgment is placed in the employee’s personnel file.

IMPLEMENTATION

The Associate Vice President for Auxiliary Operations and Enterprise Development or his/her designee, in accordance with the applicable auxiliary corporation Management Services Agreement, has the authority to implement this policy.

ACKNOWLEDGMENT

Drug Free Workplace Policy
California State University, Fresno Foundation

I understand that the Foundation is committed to protecting the safety, health and well-being of all employees and other individuals in the workplace. It is also my understanding that the drug-free workplace policy is intended to apply whenever anyone is representing or conducting business for the organization. Therefore, I understand that I am expected and required to report to work on time and in an appropriate mental and physical condition for work. Furthermore, I acknowledge that if I am convicted of a criminal drug violation in the workplace I must notify the organization in writing within five calendar days of the conviction.

Employee Acknowledgement: I certify that I have read and understand the contents contained in the Drug Free Workplace Policy for California State University, Fresno Foundation. I understand a copy of this agreement will be placed in my personnel file in Human Resources.

_____ _____

Employee Signature Date

California State University
Fresno Foundation

INJURY AND ILLNESS PREVENTION PROGRAM

INTRODUCTION

CALIFORNIA STATE UNIVERSITY, FRESNO FOUNDATION is concerned about the welfare of all of its employees, and is committed to providing a healthful and safe working environment for everyone. In demonstrating our commitment, and to facilitate achievement of our goal, CALIFORNIA STATE UNIVERSITY, FRESNO FOUNDATION has implemented a comprehensive safety plan, including important policies and procedures that all employees are required to follow. Safety, though, is a mutual responsibility. Regardless of how detailed our overall safety program is, it cannot cover every possible work situation. By being alert for possible hazards and unsafe conditions or acts, you can help ensure your safety and that of your co-workers.

This Injury Illness Prevention Program document is a summary of our overall safety and health program. It highlights the general areas of our safety and health plan, and identifies responsible parties. Detailed policies, procedures, and safe practices are available covering our entire program. Any questions or concerns should be addressed to the Director of Human Resources for Auxiliary Services. CALIFORNIA STATE UNIVERSITY, FRESNO FOUNDATION expects each employee to understand and follow the guidelines printed on the following pages.

APPROVAL

The Executive Director of Auxiliary Services has approved this IIPP dated 04/01/08, which has been written according to Cal/OSHA Standard 8, CCR 3203. This summary and all supporting policies and procedures are effective May 1, 2008 and supersede any other written and verbal safety procedures previously implemented.

Deborah S. Adishian-Astone
Executive Director of Auxiliary Services

Date 4/29/08

RESPONSIBILITY

The Director of Human Resources has the responsibility for administering and maintaining the Injury and Illness Prevention Program (IIPP).

All employees are responsible for reading, understanding and following the IIPP in their work areas. A copy of this IIPP is available from the Human Resources Department.

COMPLIANCE

All employees are responsible for complying with safe and healthful work practices. Our system of ensuring that all employees comply with these practices includes the following:

- Informing employees of the provisions of our IIPP.
- Evaluating the safety performance of all employees.
- Recognizing employees who perform safe and healthful work practices.
- Providing training to employees whose safety performance is deficient.
- Disciplining employees for failure to comply with safe and healthful work practices.

COMMUNICATION

The Director of Human Resources is responsible for communicating with all employees about occupational safety and health in a form readily understandable by all employees. Our communications system encourages all employees to inform their immediate supervisor/manager about workplace hazards without fear of reprisal.

Our communication system includes:

- New employee orientations including a discussion of safety and health policies and procedures.
- Review of our IIPP with all employees.
- Workplace safety and health training.
- Effective communication of safety and health.
- Regularly scheduled safety meetings.
- Posted and distributed safety information.
- A safety suggestion box that allows employees to anonymously inform management about workplace hazards.

HAZARD ASSESSMENT

Periodic inspections to identify and evaluate workplace hazards will be performed by the Foundation Safety Committee. Inspections will occur according to the following schedule:

- Quarterly
- When we initially established our IIPP.
- When new substances, processes, procedures, or equipment, which present potential new hazards are introduced into our workplace.
- When new, previously unidentified hazards are recognized.
- When we hire and/or reassign employees to departments, operations or tasks for which a hazard evaluation has not been previously conducted.
- When occupational injuries and illnesses occur.
- Whenever workplace conditions warrant an inspection.

INVESTIGATIONS OF INJURIES, ILLNESS AND ACCIDENTS

Workplace injuries and illnesses will be investigated to determine if any preventable safety or health hazard contributed to the occurrence. The Department Manager will conduct the investigation in a timely manner after being advised of the incident. If a reportable serious injury or death results, the investigator will ensure that a report is made to Cal/OSHA within eight hours. Any hazardous condition or work practice that contributed to the injury, illness or accident will be abated according to the following Hazard Correction Policy.

HAZARD CORRECTION

Unsafe and unhealthy work-conditions, practices or procedures will be corrected in a timely manner based on the severity of the hazards. Hazards will be corrected according to the following procedures:

- When observed or discovered, hazards that do not pose an imminent danger will be corrected as soon as possible. If the hazard cannot be corrected immediately, a safe practice will be established and employees exposed to the hazard will be trained to avoid any injury. In addition, personal protective equipment will be provided as needed. The hazard will be scheduled for correction.
- When an imminent hazard exists which cannot be immediately corrected without endangering employees and/or property, we will remove all exposed employees from the area except those necessary to correct the existing condition. Employees who are required to correct the hazardous condition will be provided with the necessary protection.

TRAINING AND INSTRUCTION

All employees will have training and instruction on general and job specific safety and health practices. Training and instruction is provided as follows:

- When the IIPP is first established.
- To all new employees.
- To all employees given new job assignments for which training has not previously been provided.
- Whenever new substances, processes, procedures or equipment are introduced to the workplace and represent a new hazard.
- Whenever the Company is made aware of a new or previously unrecognized hazard.
- To supervisors to familiarize them with the safety and health hazards to which employees under their immediate direction and control may be exposed.
- To all employees with respect to hazards specific to each employees job assignment.

General workplace safety and health practices include, but are not limited to the following:

- Explanation of the Company's IIPP, emergency action plan, fire prevention plan, hazard communication program and measures for reporting any unsafe conditions, work practices, injuries and when additional instruction is needed.
- Use of appropriate clothing and any additional personal protective equipment.
- Safe lifting, carrying and bending procedures.
- Use of equipment, machinery as applicable
- Ergonomic safety; prevention of repetitive motion injuries and musculoskeletal disorders
- Information about chemical hazards to which employees could be exposed and other hazard communication program information including proper labeling of containers.
- Provisions for medical services and first aid including emergency procedures.
- Availability of restroom and drinking facilities.

RECORDKEEPING

We have taken the following steps to implement and maintain our IIPP:

- Records of hazard assessment inspections, including the person(s) conducting the inspection, the unsafe conditions and work practices that have been identified and the action taken to correct the identified unsafe conditions and work practices, are recorded on a hazard assessment and correction form.
- Documentation of safety and health training for each employee, including the employee's name, training dates, type(s) of training, and training providers are recorded on an employee training and instruction form.

Inspection records and training documentation will be maintained for three (3) years.

CALIFORNIA STATE UNIVERSITY, FRESNO FOUNDATION

EMPLOYEE RECEIPT AND ACKNOWLEDGMENT OF INJURY AND ILLNESS PREVENTION PROGRAM

CALIFORNIA STATE UNIVERSITY, FRESNO FOUNDATION'S Injury and Illness Prevention Program has been reviewed with me this day. I acknowledge that I had the opportunity to review the document myself, that I understand it is my responsibility to understand the requirements of the Program, and to ensure that I follow all related safe practices and procedures. I am aware that the IIPP is available for my review at my work site.

Signature _____

Print Name _____

Date _____

ACKNOWLEDGMENT

This Employee Handbook describes important information about the California State University, Fresno Foundation (Foundation). I understand that I should consult Auxiliary Human Resources regarding any questions not answered in this Handbook.

I have entered into my employment relationship with the Foundation voluntarily, and acknowledge there is no specified length of employment. I understand the Foundation is an at-will employer, which means I can terminate my employment at any time, with or without advance notice, with or without cause, and the Foundation has similar rights.

No manager, supervisor, or employee of the Foundation has authority to enter into any agreement for employment, for any specified period of time or to make any agreement for employment other than at-will.

Since the information, policies, and benefits described are subject to change, I acknowledge changes and revisions may occur and that such changes will be communicated through appropriate notices, and that those changes may modify, eliminate, reduce or improve existing policies and benefits.

I agree to read the Employment Handbook, whether in paper form or electronic form, read all changes in a timely manner, and agree to comply with the policies contained in the Handbook and any revisions made to it.

PRINT FULL NAME _____

EMPLOYEE SIGNATURE _____

DATE _____

Reset Form

Employment Eligibility Verification

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

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

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

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

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

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

Address *(Street Number and Name)*	Apt. Number	City or Town	State	ZIP Code

Date of Birth *(mm/dd/yyyy)*	U.S. Social Security Number	Employee's E-mail Address	Employee's Telephone Number
	☐☐☐ - ☐☐ - ☐☐☐☐		

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

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

☐ 1. A citizen of the United States

☐ 2. A noncitizen national of the United States *(See instructions)*

☐ 3. A lawful permanent resident (Alien Registration Number/USCIS Number): _____

☐ 4. An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy): _____
Some aliens may write "N/A" in the expiration date field. *(See instructions)*

Aliens authorized to work must provide only one of the following document numbers to complete Form I-9:
An Alien Registration Number/USCIS Number OR Form I-94 Admission Number OR Foreign Passport Number.

1. Alien Registration Number/USCIS Number: _____
OR
2. Form I-94 Admission Number: _____
OR
3. Foreign Passport Number: _____
Country of Issuance: _____

QR Code - Section 1
Do Not Write In This Space

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

Preparer and/or Translator Certification (check one):

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

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

Signature of Preparer or Translator	Today's Date *(mm/dd/yyyy)*

Last Name *(Family Name)*	First Name *(Given Name)*

Address *(Street Number and Name)*	City or Town	State	ZIP Code

STOP *Employer Completes Next Page* STOP

Reset Form

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

List A Identity and Employment Authorization	OR	List B Identity	AND	List C Employment Authorization
Document Title		Document Title		Document Title
Issuing Authority		Issuing Authority		Issuing Authority
Document Number		Document Number		Document Number
Expiration Date *(if any) (mm/dd/yyyy)*		Expiration Date *(if any) (mm/dd/yyyy)*		Expiration Date *(if any) (mm/dd/yyyy)*
Document Title				
Issuing Authority				
Document Number				
Expiration Date *(if any) (mm/dd/yyyy)*				
Document Title				
Issuing Authority				
Document Number				
Expiration Date *(if any) (mm/dd/yyyy)*				

Additional Information

QR Code - Section 2
Do Not Write In This Space

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

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

Signature of Employer or Authorized Representative	Today's Date *(mm/dd/yyyy)*	Title of Employer or Authorized Representative

Last Name of Employer or Authorized Representative	First Name of Employer or Authorized Representative	Employer's Business or Organization Name
		CSU, Fresno Foundation

Employer's Business or Organization Address (*Street Number and Name*)	City or Town	State	ZIP Code
4910 N. Chestnut Ave.	Fresno	CA	93726

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

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

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

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

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

Signature of Employer or Authorized Representative	Today's Date *(mm/dd/yyyy)*	Name of Employer or Authorized Representative

LISTS OF ACCEPTABLE DOCUMENTS
All documents must be UNEXPIRED

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

LIST A Documents that Establish Both Identity and Employment Authorization	OR	LIST B Documents that Establish Identity	AND	LIST C Documents that Establish Employment Authorization
1. U.S. Passport or U.S. Passport Card		**1.** Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		**1.** A Social Security Account Number card, unless the card includes one of the following restrictions: (1) NOT VALID FOR EMPLOYMENT (2) VALID FOR WORK ONLY WITH INS AUTHORIZATION (3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION
2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)		**2.** ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		**2.** Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240)
3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa		**3.** School ID card with a photograph		**3.** Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal
4. Employment Authorization Document that contains a photograph (Form I-766)		**4.** Voter's registration card		**4.** Native American tribal document
5. For a nonimmigrant alien authorized to work for a specific employer because of his or her status: **a.** Foreign passport; and **b.** Form I-94 or Form I-94A that has the following: (1) The same name as the passport; and (2) An endorsement of the alien's nonimmigrant status as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form.		**5.** U.S. Military card or draft record		**5.** U.S. Citizen ID Card (Form I-197)
		6. Military dependent's ID card		**6.** Identification Card for Use of Resident Citizen in the United States (Form I-179)
		7. U.S. Coast Guard Merchant Mariner Card		**7.** Employment authorization document issued by the Department of Homeland Security
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		**8.** Native American tribal document		
		9. Driver's license issued by a Canadian government authority		
		For persons under age 18 who are unable to present a document listed above:		
		10. School record or report card		
		11. Clinic, doctor, or hospital record		
		12. Day-care or nursery school record		

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

Refer to the instructions for more information about acceptable receipts.

Form **W-4**

Department of the Treasury
Internal Revenue Service

Employee's Withholding Certificate

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

OMB No. 1545-0074

2022

Step 1: Enter Personal Information

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

(c) ☐ **Single** or **Married filing separately**
☐ **Married filing jointly** or **Qualifying widow(er)**
☐ **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 estimator at *www.irs.gov/W4App*, 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 2022 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 total income will be $200,000 or less ($400,000 or less if married filing jointly):

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

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

Add the amounts above 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)
California State University, Fresno Foundation **4910 N. Chestnut Ave.** **Fresno, CA 93726**		**94-6003272**

General Instructions

Section references are to the Internal Revenue Code.

Future Developments

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

Purpose of Form

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

Exemption from withholding. You may claim exemption from withholding for 2022 if you meet both of the following conditions: you had no federal income tax liability in 2021 **and** you expect to have no federal income tax liability in 2022. You had no federal income tax liability in 2021 if (1) your total tax on line 24 on your 2021 Form 1040 or 1040-SR is zero (or less than the sum of lines 27a, 28, 29, and 30), 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 2022 tax return. To claim exemption from withholding, certify that you meet both of the conditions above by writing "Exempt" on Form W-4 in the space below Step 4(c). Then, complete Steps 1(a), 1(b), and 5. Do not complete any other steps. You will need to submit a new Form W-4 by February 15, 2023.

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

Step 4 (optional).

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

Step 4(b). Enter in this step the amount from the Deductions Worksheet, line 5, if you expect to claim deductions other than the basic standard deduction on your 2022 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 . . . . . 1 $ _____

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

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

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

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

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

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

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

1 Enter an estimate of your 2022 itemized deductions (from Schedule A (Form 1040)). Such deductions may include qualifying home mortgage interest, charitable contributions, state and local taxes (up to $10,000), and medical expenses in excess of 7.5% of your income . . . . . 1 $ _____

2 Enter:
- $25,900 if you're married filing jointly or qualifying widow(er)
- $19,400 if you're head of household
- $12,950 if you're single or married filing separately

. . . . . 2 $ _____

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

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

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

Privacy Act and Paperwork Reduction Act Notice. We ask for the information on this form to carry out the Internal Revenue laws of the United States. Internal Revenue Code sections 3402(f)(2) and 6109 and their regulations require you to provide this information; your employer uses it to determine your federal income tax withholding. Failure to provide a properly completed form will result in your being treated as a single person with no other entries on the form; providing fraudulent information may subject you to penalties. Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation; to cities, states, the District of Columbia, and U.S. commonwealths and 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	$110	$850	$860	$1,020	$1,020	$1,020	$1,020	$1,020	$1,020	$1,770	$1,870
$10,000 - 19,999	110	1,110	1,860	2,060	2,220	2,220	2,220	2,220	2,220	2,970	3,970	4,070
$20,000 - 29,999	850	1,860	2,800	3,000	3,160	3,160	3,160	3,160	3,910	4,910	5,910	6,010
$30,000 - 39,999	860	2,060	3,000	3,200	3,360	3,360	3,360	4,110	5,110	6,110	7,110	7,210
$40,000 - 49,999	1,020	2,220	3,160	3,360	3,520	3,520	4,270	5,270	6,270	7,270	8,270	8,370
$50,000 - 59,999	1,020	2,220	3,160	3,360	3,520	4,270	5,270	6,270	7,270	8,270	9,270	9,370
$60,000 - 69,999	1,020	2,220	3,160	3,360	4,270	5,270	6,270	7,270	8,270	9,270	10,270	10,370
$70,000 - 79,999	1,020	2,220	3,160	4,110	5,270	6,270	7,270	8,270	9,270	10,270	11,270	11,370
$80,000 - 99,999	1,020	2,820	4,760	5,960	7,120	8,120	9,120	10,120	11,120	12,120	13,150	13,450
$100,000 - 149,999	1,870	4,070	6,010	7,210	8,370	9,370	10,510	11,710	12,910	14,110	15,310	15,600
$150,000 - 239,999	2,040	4,440	6,580	7,980	9,340	10,540	11,740	12,940	14,140	15,340	16,540	16,830
$240,000 - 259,999	2,040	4,440	6,580	7,980	9,340	10,540	11,740	12,940	14,140	15,340	16,540	17,590
$260,000 - 279,999	2,040	4,440	6,580	7,980	9,340	10,540	11,740	12,940	14,140	16,100	18,100	19,190
$280,000 - 299,999	2,040	4,440	6,580	7,980	9,340	10,540	11,740	13,700	15,700	17,700	19,700	20,790
$300,000 - 319,999	2,040	4,440	6,580	7,980	9,340	11,300	13,300	15,300	17,300	19,300	21,300	22,390
$320,000 - 364,999	2,100	5,300	8,240	10,440	12,600	14,600	16,600	18,600	20,600	22,600	24,870	26,260
$365,000 - 524,999	2,970	6,470	9,710	12,210	14,670	16,970	19,270	21,570	23,870	26,170	28,470	29,870
$525,000 and over	3,140	6,840	10,280	12,980	15,640	18,140	20,640	23,140	25,640	28,140	30,640	32,240

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	$400	$930	$1,020	$1,020	$1,250	$1,870	$1,870	$1,870	$1,870	$1,970	$2,040	$2,040
$10,000 - 19,999	930	1,570	1,660	1,890	2,890	3,510	3,510	3,510	3,610	3,810	3,880	3,880
$20,000 - 29,999	1,020	1,660	1,990	2,990	3,990	4,610	4,610	4,710	4,910	5,110	5,180	5,180
$30,000 - 39,999	1,020	1,890	2,990	3,990	4,990	5,610	5,710	5,910	6,110	6,310	6,380	6,380
$40,000 - 59,999	1,870	3,510	4,610	5,610	6,680	7,500	7,700	7,900	8,100	8,300	8,370	8,370
$60,000 - 79,999	1,870	3,510	4,680	5,880	7,080	7,900	8,100	8,300	8,500	8,700	8,970	9,770
$80,000 - 99,999	1,940	3,780	5,080	6,280	7,480	8,300	8,500	8,700	9,100	10,100	10,970	11,770
$100,000 - 124,999	2,040	3,880	5,180	6,380	7,580	8,400	9,140	10,140	11,140	12,140	13,040	14,140
$125,000 - 149,999	2,040	3,880	5,180	6,520	8,520	10,140	11,140	12,140	13,320	14,620	15,790	16,890
$150,000 - 174,999	2,040	4,420	6,520	8,520	10,520	12,170	13,470	14,770	16,070	17,370	18,540	19,640
$175,000 - 199,999	2,720	5,360	7,460	9,630	11,930	13,860	15,160	16,460	17,760	19,060	20,230	21,330
$200,000 - 249,999	2,970	5,920	8,310	10,610	12,910	14,840	16,140	17,440	18,740	20,040	21,210	22,310
$250,000 - 399,999	2,970	5,920	8,310	10,610	12,910	14,840	16,140	17,440	18,740	20,040	21,210	22,310
$400,000 - 449,999	2,970	5,920	8,310	10,610	12,910	14,840	16,140	17,440	18,740	20,040	21,210	22,470
$450,000 and over	3,140	6,290	8,880	11,380	13,880	16,010	17,510	19,010	20,510	22,010	23,380	24,680

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	$760	$910	$1,020	$1,020	$1,020	$1,190	$1,870	$1,870	$1,870	$2,040	$2,040
$10,000 - 19,999	760	1,820	2,110	2,220	2,220	2,390	3,390	4,070	4,070	4,240	4,440	4,440
$20,000 - 29,999	910	2,110	2,400	2,510	2,680	3,680	4,680	5,360	5,530	5,730	5,930	5,930
$30,000 - 39,999	1,020	2,220	2,510	2,790	3,790	4,790	5,790	6,640	6,840	7,040	7,240	7,240
$40,000 - 59,999	1,020	2,240	3,530	4,640	5,640	6,780	7,980	8,860	9,060	9,260	9,460	9,460
$60,000 - 79,999	1,870	4,070	5,360	6,610	7,810	9,010	10,210	11,090	11,290	11,490	11,690	12,170
$80,000 - 99,999	1,870	4,210	5,700	7,010	8,210	9,410	10,610	11,490	11,690	12,380	13,370	14,170
$100,000 - 124,999	2,040	4,440	5,930	7,240	8,440	9,640	10,860	12,540	13,540	14,540	15,540	16,480
$125,000 - 149,999	2,040	4,440	5,930	7,240	8,860	10,860	12,860	14,540	15,540	16,830	18,130	19,230
$150,000 - 174,999	2,040	4,460	6,750	8,860	10,860	12,860	15,000	16,980	18,280	19,580	20,880	21,980
$175,000 - 199,999	2,720	5,920	8,210	10,320	12,600	14,900	17,200	19,180	20,480	21,780	23,080	24,180
$200,000 - 449,999	2,970	6,470	9,060	11,480	13,780	16,080	18,380	20,360	21,660	22,960	24,250	25,360
$450,000 and over	3,140	6,840	9,630	12,250	14,750	17,250	19,750	21,930	23,430	24,930	26,420	27,730

Employment Development Department
State of California

Clear Form

EMPLOYEE'S WITHHOLDING ALLOWANCE CERTIFICATE

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

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

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

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

Exemption from Withholding

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

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

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

Employee's Signature _____ Date _____

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

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

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

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

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

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

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

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

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

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

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

(iii) you maintain your domicile in another state.

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

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

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

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

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

INSTRUCTIONS — 1 — ALLOWANCES*

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

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

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

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

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

WORKSHEET A **REGULAR WITHHOLDING ALLOWANCES**

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

INSTRUCTIONS — 2 — (OPTIONAL) ADDITIONAL WITHHOLDING ALLOWANCES

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

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

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

WORKSHEET B **ESTIMATED DEDUCTIONS**

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

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

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

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

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

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

THESE TABLES ARE FOR CALCULATING WORKSHEET C AND FOR 2020 ONLY

SINGLE PERSONS, DUAL INCOME MARRIED WITH MULTIPLE EMPLOYERS

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

UNMARRIED HEAD OF HOUSEHOLD

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

MARRIED PERSONS

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

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

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

California State University Fresno, Foundation 401K Retirement Plan

Plan Benefits

Contibutions not taxed when made.	Tax deferred growth on assets.	Benefits are non-assignable.	Non-discriminatory benefits.	100% vested upon initial contribution deposit.	Rollover assets are allowed and 100% vested.

Plan Eligibility

Eligibility begins the month of entry.	No age or service requirements.

Contribution Types

Employee: Pre-Tax, $0- $17,500 per year. An additional $5,500 a year can be contributed if over the age of 50.

Distributions

Retirement, age 65.	In-Service distribution at age 59 ½.	Total and permanent dissability.	Death; benefits to beneficiaries.	Termination of service.	Hardship withdrawal (Subject to administrator approval.)

A "SUMMARY PLAN DESCRIPTION" can be requested from Human Resources for more details.

Reset Form

Participant Record/Contribution Change Form

Group Number:	Social Security Number:		
GENERAL INFORMATION (Please print or type) Plan Name:			
Employee Name: ☐**Change** ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss	Last:	First:	M.I.:
Address: ☐**Change**			
City:		State:	Zip:
Date of Birth:	Date of Hire:	Date of Eligibility:	Date of Rehire: (if applicable)

Please refer to the Plan, the summary plan description or contact your Plan Administrator for information on the options available under the Plan.

CONTRIBUTIONS

A. ☐ **Elective Deferrals** - I elect to contribute $_____ of my compensation each payroll period on a before-tax basis. (Must be a flat amount)

B. ☐ I wish to discontinue my contributions effective _____.

C. ☐ I wish to not participate in elective deferrals effective _____.

SALARY REDUCTION AGREEMENT

If elected above, by execution of the Participant Record/Contribution Change Form, I authorize my Employer to make contributions to the Plan by reducing my compensation as elected. This agreement shall continue in effect while I am employed by the Employer or until it is changed in accordance with the terms of the Plan. I understand that the terms of the Plan may provide the Employer with the authority to reduce or cease my 401(k) contributions to ensure the Plan satisfies the requirements of Section 401(k) of the Internal Revenue Code.

SIGNATURES

I acknowledge that I have read and understand the state-specific Fraud Warning Statement, or the NAIC Model Fraud Statement,as applicable.

_____ _____

Employee Signature Date

This Document has been received and accepted by the Plan Administrator.

_____ _____

Plan Administrator Signature Date

To be retained by the Plan Administrator

Reset Form

Beneficiary Designation Form

Use this form if you want to:
• add a primary or contingent beneficiary to your account
• change an existing primary or contingent beneficiary
If you do not complete, sign (including spouse signature, if applicable), and submit this form to the plan administrator, you will not have a valid beneficiary designation. If you do not have a valid *Beneficiary Designation Form* on file, the Plan document will determine the designated beneficiary upon your death. Please refer to Beneficiary Designation Instructions on page 3 for more information about designating a beneficiary.
• Married Participants – If you want to designate a beneficiary other than your spouse, you must obtain spousal consent for that designation. If you divorce or become legally separated, please contact your Plan Administrator to determine whether the divorce or separation automatically results in removal of your former spouse, as beneficiary.
• Unmarried Participants – If you are unmarried at the time you complete this form and later marry, this form will no longer be valid once the Plan recognizes your spouse. At that time if you want to name someone other than your spouse as designated beneficiary, you will need to complete a new form and obtain spousal consent.
Note: If your plan's normal form of benefit is an annuity, please contact your Plan Administrator to obtain a copy of a Qualified Pre-Retirement Survivor Annuity Notice. If you are married, your spouse has survivor rights to your account that are important for you to understand before you complete this form. Refer to your plan's Summary Plan Description to determine the normal form of benefit.

Section A - Plan Information

Plan ID	Plan Name

Section B - Participant Information

Social Security Number	Participant Name	Daytime Phone Number	

Legal Address	City	State	Zip Code

Marital Status: (select one)	Date of Hire
☐ Married ☐ Unmarried	

Section C - Primary Beneficiary

I hereby name the following as my Primary Beneficiary(ies) to receive the Plan's death benefit upon my death:

Name, address and phone no. of Primary Beneficiary(ies)	SSN or Taxpayer ID No.	Date of Birth	Relationship	Whole Percent
			☐ Spouse ☐ Child ☐ Trust ☐ Other_____	%
			☐ Spouse ☐ Child ☐ Trust ☐ Other_____	%
			☐ Spouse ☐ Child ☐ Trust ☐ Other_____	%
			☐ Spouse ☐ Child ☐ Trust ☐ Other_____	%

Total 100%

Section D - Contingent Beneficiary

In the event there is no living Primary Beneficiary(ies) upon my death, I hereby name the following as my Contingent Beneficiary(ies):

Name, address and phone no. of Contingent Beneficiary(ies)	SSN or Taxpayer ID No.	Date of Birth	Relationship	Whole Percent
			☐ Spouse ☐ Child ☐ Trust ☐ Other_____	%
			☐ Spouse ☐ Child ☐ Trust ☐ Other_____	%
			☐ Spouse ☐ Child ☐ Trust ☐ Other_____	%
			☐ Spouse ☐ Child ☐ Trust ☐ Other_____	%

Total 100%

Section E - Participant Certification and Authorization (you must sign this section)

I, the participant, hereby instruct the Plan to distribute my death benefit to the designated beneficiary(ies) herein. I acknowledge that:

- If I am married, I must obtain spousal consent if all or a portion of my death benefit is to be paid to someone other than my spouse.
- **If the Plan's normal form of benefit is an annuity**, I have read the Qualified Pre-Retirement Survivor Annuity Notice and provided a properly executed waiver. If not, this designation is not valid.
- I reserve the right to revoke or change any beneficiary designation (with spousal approval, if applicable) by submitting a new form.
- This form is not valid if it is not received by the Plan in good order before my death and/or if there is no Primary or Contingent beneficiary(ies) living upon my death.
- This form supersedes any prior beneficiary designation and, if my beneficiary designation is valid under the Plan, identifies all current Primary and Contingent beneficiary(ies).
- I understand that if I do not provide a valid beneficiary designation, and the Plan does not provide for a default beneficiary, then my beneficiary will be my estate.

_____ _____

Participant's Signature Date

Section F - Spousal Consent (complete only if the participant is married)

I certify that I am the spouse of the participant and I hereby voluntarily consent to the participant's (i.e., my spouse) beneficiary designation herein. I acknowledge that:

- If the Plan's normal form of benefit is an annuity, I have received and read the Qualified Pre-Retirement Survivor Annuity Notice.
- I understand the effect of such beneficiary designation is to cause my spouse's (i.e. the Participant) death benefit, or portion of it, to be paid to a beneficiary other than me.
- Each beneficiary designation is not valid unless I consent to it.
- My consent is irrevocable unless my spouse revokes the beneficiary designation.

_____ _____

Participant Spouse's Signature Date

Section G - Witness Certification and Signature (Plan Administrator or Notary completes)

I certify that the married participant's spouse personally appeared before me and acknowledged that she/he signed the Section F - Spousal Consent as her/his free act and deed.

If the plan administrator does not witness the spouse's signature, a Notary must witness it.

If witnessed by a Notary Public the Signature/Stamp must be also provided below for this form to be considered valid.

_____

Signature of Witness (Plan Administrator or Notary Public)

Notary Public stamp here:

If signed by a Notary Public, please complete the following:

Sworn before me this day: _____

In the State of _____, County of _____

Commission Expiration Date: _____

Participants must submit this form to the Plan Administrator.

Beneficiary Designation Instructions

A beneficiary is a person, institution, charitable organization, or irrevocable or revocable trust named by you, the participant, to receive payment of benefits provided under the Plan in the event of your death. You may designate more than one Primary Beneficiary who will share in the Plan's death benefit. You may also designate one or more Contingent Beneficiary(ies). A Contingent Beneficiary would receive payment only if the Primary Beneficiary(ies) you named were not able to receive payment at the time that payment was to be made.

The beneficiary designation should not include wording such as "either/or" or "and/or." Use only whole-number percentages equaling 100%. For example, designations such as 33 1⁄3 or 33.3 are not acceptable. If there is more than one designated beneficiary the percent payable under each category must add up to 100%.

Beneficiary Names: A married individual should be indicated by their full given name and not that of his/her spouse. For example: use Jane Doe and not Mrs. John Doe.

Multiple Beneficiaries: If you name more than one beneficiary in either the Primary or Contingent Beneficiary category, beneficiaries in the affected category will share equally unless otherwise indicated.

Naming Your Estate: If you designate your estate as the beneficiary you must indicate on the beneficiary form "PAY TO THE ESTATE OF…". You should contact a tax or estate planner before designating your estate as your designated beneficiary.

Naming a Trust: If you designate a revocable or irrevocable trust as your beneficiary, please include the trust's name and address, the date the trust was created, the trustee's name and the trust's Tax Identification Number on the Beneficiary Designation Form. A copy of the executed trust agreement should also be provided to the Plan Administrator at the time of your designation. Please note there are special required distribution rules that apply to trusts under Treasury regulations §1.401(a)(9)-4. You should contact a tax or estate planner before designating a trust as your designated beneficiary.

Naming a Minor: If you designate a minor as your beneficiary, you must generally provide information about the appointed guardian (or custodian under the minor beneficiary's state Uniform Gift (or Transfer) to Minor Act) who will act on the behalf of the minor's property from the date of your death until the minor attains legal age. Provide the minor beneficiary's social security number. You cannot designate unborn children as beneficiaries. You should contact a tax or estate planner before designating a minor as your designated beneficiary.

If you would like to name more than four primary and four contingent beneficiaries, make a copy of page 1 and attach it to this form.

2022 Semi-Monthly Payroll Schedule

California State University, Fresno Association, Inc.
California State University, Fresno Athletic Corporation
California State University, Fresno Foundation
Agricultural Foundation of California State University, Fresno
Associated Students Inc. of California State University, Fresno
Fresno State Programs for Children, Inc.

Pay Period	Time-Sheet Due	Date Paychecks Available
December 16-31	January 3	**Friday, January 7**
January 1-15	January 18	**Friday, January 21**
January 16-31	February 1	**Monday, February 7**
February 1-15	February 16	**Tuesday, February 22**
February 16-28	March 1	**Monday, March 7**
March 1-15	March 16	**Tuesday, March 22**
March 16-31	April 1	**Thursday, April 7**
April 1-15	April 18	**Friday, April 22**
April 16-30	May 2	**Friday, May 6**
May 1-15	May 16	**Friday, May 20**
May 16-31	June 1	**Tuesday, June 7**
June 1-15	June 16	**Wednesday, June 22**
June 16-30	July 1	**Thursday, July 7**
July 1-15	July 18	**Friday, July 22**
July 16-31	August 1	**Friday, August 5**
August 1-15	August 16	**Monday, August 22**
August 16-31	September 1	**Wednesday, September 7**
September 1-15	September 16	**Thursday, September 22**
September 16-30	October 3	**Friday, October 7**
October 1-15	October 17	**Friday, October 21**
October 16-31	November 1	**Monday, November 7**
November 1-15	November 16	**Tuesday, November 22**
November 16-30	December 1	**Wednesday, December 7**
December 1-15	December 16	**Thursday, December 22**

ALL PAYROLL CHECKS ARE AVAILABLE
AFTER 1:00 PM ON THE DATE SHOWN ABOVE

Dear Employee:

New Health Insurance Marketplace Coverage Options and Your Health Coverage

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

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

Can I Save Money on my Health Insurance Premiums in the Marketplace?
You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

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

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

How Can I Get More Information?
For more information about your coverage offered by your employer, please check your summary plan description or contact Auxiliary Human Resources at (559) 278-0865.

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

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

Form Approved
OMB No. 1210-0149
(expires 11-30-2013)

PART B: Information About Health Coverage Offered by Your Employer

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

3. Employer Name *California State University, Fresno Association Inc.*	4. Employer Identification Number (EIN) *94-1512286*	
5. Employer Address *2771 E. Shaw Avenue*	6. Employer Phone Number (559) 278-0865	
7. City *Fresno*	8. State *CA*	9. ZIP Code *93710*
10. Who can we contact about employee health coverage at this job? *Nicole Lane*		
11. Phone Number (if different than above)	12. Email address *nicolel@csufresno.edu*	

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

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

  ☐ All employees

  ☒ Some employees. Eligible employees are:

  Benefited employees (also called regular or full time employees).

- With respect to dependents:

  ☒ We do offer coverage. Eligible dependents are:

  A spouse, a domestic partner of the same sex as the Employee, or a domestic partner of the opposite sex of the Employee provided the partner is over age 62 and is registered with the California State Registry; and a child, stepchild or other eligible dependent up to age 26.

  ☐ We do not offer coverage

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

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

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

HOURLY TIME AND EFFORT REPORT

CALIFORNIA STATE UNIVERSITY, FRESNO FOUNDATION

EMPLOYEE INFORMATION

Employee Name (Last, First MI):	Auxiliary ID:
University E-Mail Address:	Employee Type:

** Payroll Overload Approval Form Required*

PAY PERIOD INFORMATION

Current Year: 2015 Current Month:

HOURS WORKED

Date	Time In	Time Out	Time In	Time Out	Total Hrs	ST	OT
					0.00	0.00	0.00
					0.00	0.00	0.00
3rd					0.00	0.00	0.00
4th					0.00	0.00	0.00
h					0.00	0.00	0.00
					0.00	0.00	0.00
					0.00	0.00	0.00
					0.00	0.00	0.00
					0.00	0.00	0.00
0th					0.00	0.00	0.00
11th					0.00	0.00	0.00
1					0.00	0.00	0.00
13th					0.00	0.00	0.00
14th					0.00	0.00	0.00
15th					0.00	0.00	0.00

S LE U

Date	Hours sed	Dat	Total Sick

POSITION AND CO T CE R

Position:		Hourl of Pay:	
CC Name:		CC No Sub:	

COMPENSATION SUMMARY

	Hours	Rate	Total	O W	
Straight Time:	0.00	$0.00	$0.00	Total Hours:	
Sick Time:	0.00	$0.00	$0.00	Total Sick Hours:	0.00
Overtime:	0.00	$0.00	$0.00	Total Wages:	$0.00

For flat rate compensation, please click here ☐ Flat Rate Amount: _____

Please attach written justification for all flat rate compensation requests.

EMPLOYEE CERTIFICATION

I hereby certify under penalty of perjury that I have worked all hours indicated above and that all effort included in this report was performed exclusively for the grant, contract, agreement, or account application associated with the cost center indicated on this form. Furthermore, I certify that I have received all meal and rest breaks to which I was legally entitled and that all overtime worked was approved prior to the work being performed.

EMPLOYEE SIGNATURE _____ DATE

SUPERVISOR CERTIFICATION

I hereby certify that I have verified and authorized the hours worked as stated above, believe them to be a true and accurate representation of effort, and affirm that sufficient money is on deposit with the Auxiliary Corporations to pay this voucher.

SUPERVISOR NAME SUPERVISOR SIGNATURE _____ DATE

REV7.1.15

Submit timesheets to Foundation Financial Services at Mail Stop OF123
or via postal mail to 4910 N. Chestnut Ave., Fresno, CA 93710

Reset Form

FRESNO STATE

Auxiliary Services

Authorization for Direct Deposit of Payroll

Type of Enrollment Action:	Social Security Number OR Auxiliary ID Number:
☐ **NEW** ☐ **CHANGE** ☐ **CANCEL**	Name: (First Middle Last)

To be Completed by Employee if NEW or CHANGE is Checked

Type of Account: ☐ Checking ☐ Savings

Numbers on Form Must Match Supporting Documentation

Routing Number:	Account Number:
Financial Institution Name:	
Financial Institution Address:	

To be Completed by Employee if NEW or CHANGE is Checked

☐ I authorize Auxiliary Services to perform electronic credit entries, and if necessary, and debit entries that are in error to my account, to the financial institution account named above. This authority will remain in force until I have given written notification to terminate it.

Signature	Date

To be Completed by Employee if CANCEL is Checked

☐ I authorize Auxiliary Services to cancel my Direct Deposit.

Signature	Date

Please staple a voided check in this area.

If checks not available, please attach official bank documentation.