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
. . . . . 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.

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 Phone)*

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: _____

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

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

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.							

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

FRESNO STATE
Auxiliary Services

Employee Emergency Contact Information

Please complete the following information (please print):

Employee Name: _____ Contact Number: _____

Full Address: _____

In case of emergency, notify the following:

Name: _____ Relationship: _____

Full Address: _____

Contact Number: _____ Additional # (if applicable): _____

Pre-Designation of Physician for Work-Related Injury

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

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

Employee Signature: _____ Date: _____

Revised: 5/5/2023

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*]

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 General 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 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)).

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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):
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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.

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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).

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- 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: _____

FRESNO STATE

Auxiliary Services

Agreement for Waiver of Meal Period- Fresno State Foundation

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 waived any meal period on the work shift.

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, psycholsis, 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 _____

Employment Eligibility Verification

Department of Homeland Security

U.S. Citizenship and Immigration Services

USCIS Form I-9

OMB No.1615-0047

Expires 07/31/2026

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

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

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

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

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

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

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

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

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

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

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

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

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

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

	List A	OR	List B	AND	List C
Document Title 1					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 2 (if any)					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 3 (if any)					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					

Additional Information

☐ Check here if you used an alternative procedure authorized by DHS to examine documents.

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

First Day of Employment (mm/dd/yyyy):

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

Employer's Business or Organization Name	Employer's Business or Organization Address, City or Town, State, ZIP Code
CSU Fresno Foundation	**4910 N. Chestnut Ave., Fresno, CA 93726**

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

LISTS OF ACCEPTABLE DOCUMENTS

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

LIST A 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 an individual temporarily authorized to work for a specific employer because of his or her status or parole: **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 individual's status or parole as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form.		**5.** U.S. Military card or draft record		**5.** U.S. Citizen ID Card (Form I-197)
		6. Military dependent's ID card		**6.** Identification Card for Use of Resident Citizen in the United States (Form I-179)
		7. U.S. Coast Guard Merchant Mariner Card		**7.** Employment authorization document issued by the Department of Homeland Security For examples, see **Section 7** and **Section 13** of the M-274 on **uscis.gov/i-9-central**. The Form I-766, Employment Authorization Document, is a List A, **Item Number 4.** document, not a List C document.
6. Passport from the Federated States of Micronesia (FSM) or the Republic of the Marshall Islands (RMI) with Form I-94 or Form I-94A indicating nonimmigrant admission under the Compact of Free Association Between the United States and the FSM or RMI		**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		

Acceptable Receipts

May be presented in lieu of a document listed above for a temporary period.

For receipt validity dates, see the M-274.

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

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

Form **W-4**

Department of the Treasury
Internal Revenue Service

Employee's Withholding Certificate

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

OMB No. 1545-0074

2023

Step 1: Enter Personal Information

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

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

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

Step 2: Multiple Jobs or Spouse Works

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

Do **only one** of the following.

(a) Reserved for future use.

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

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

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

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

Step 3: Claim Dependent and Other Credits

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

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

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

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

Step 4 (optional): Other Adjustments

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

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

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

Step 5: Sign Here

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

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

Employers Only

Employer's name and address	First date of employment	Employer identification number (EIN)
California State University, Fresno Foundation 4910 N. Chestnut Ave. Fresno, CA 93726		94-6003272

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	Filing Status ☐ SINGLE or MARRIED (with two or more incomes) ☐ MARRIED (one income) ☐ HEAD OF HOUSEHOLD
City, State, and ZIP Code	

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

OR

Exemption from Withholding

3. I claim exemption from withholding for 2021, and I certify I meet both of the conditions for exemption. (Check box here) ☐

OR

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

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

Employee's Signature _____ Date

Employer's Section: Employer's Name and Address	California Employer Payroll Tax Account Number
California State University, Fresno Foundation	910-1750-9

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 withholding on your wages if

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

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

(iii) you maintain your domicile in another state.

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

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

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) ☐ Married ☐ Unmarried	**Date of Hire**			

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.

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.

2023 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, by 5:00 p.m.	**Friday, January 6**
January 1-15	January 17, by 5:00 p.m.	**Friday, January 20**
January 16-31	February 1, by 5:00 p.m.	**Tuesday, February 7**
February 1-15	February 16, by 5:00 p.m.	**Wednesday, February 22**
February 16-28	March 1, by 5:00 p.m.	**Tuesday, March 7**
March 1-15	March 16, by 5:00 p.m.	**Wednesday, March 22**
March 16-31	April 3, by 5:00 p.m.	**Friday, April 7**
April 1-15	April 17, by 5:00 p.m.	**Friday, April 21**
April 16-30	May 1, by 5:00 p.m.	**Friday, May 5**
May 1-15	May 16, by 5:00 p.m.	**Monday, May 22**
May 16-31	June 1, by 3:30 p.m.	**Wednesday, June 7**
June 1-15	June 16, by 3:30 p.m.	**Thursday, June 22**
June 16-30	July 3, by 3:30 p.m.	**Friday, July 7**
July 1-15	July 17, by 3:30 p.m.	**Friday, July 21**
July 16-31	August 1, by 3:30 p.m.	**Monday, August 7**
August 1-15	August 16, by 5:00 p.m.	**Tuesday, August 22**
August 16-31	September 1, by 5:00 p.m.	**Thursday, September 7**
September 1-15	September 18, by 5:00 p.m.	**Friday, September 22**
September 16-30	October 2, by 5:00 p.m.	**Friday, October 6**
October 1-15	October 16, by 5:00 p.m.	**Friday, October 20**
October 16-31	November 1, by 5:00 p.m.	**Tuesday, November 7**
November 1-15	November 16, by 5:00 p.m.	**Wednesday, November 22**
November 16-30	December 1, by 5:00 p.m.	**Thursday, December 7**
December 1-15	December 18, by 5:00 p.m.	**Friday, 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 Foundation*	4. Employer Identification Number (EIN) *94-6003272*	
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
					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:		Hourly 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

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.