

SUBSTITUTE SERVICES PROFILE

Legal Name: _____

Last

First

MI

Gender: Male ___ Female ___ SSN: _____ DOB: _____

Phone: _____ Cell: _____

(Please **check** the best phone number to call you for substitute jobs)

Email Address: _____

Address: _____

Street
Apt #
City
State
Zip

Languages Spoken: _____

Please check next to the districts you are interested in working:

Clackamas County	Clatsop County	Columbia County	Linn/Marion County
<input type="checkbox"/> North Clackamas	<input type="checkbox"/> Astoria <input type="checkbox"/> Jewell <input type="checkbox"/> Knappa <input type="checkbox"/> Seaside <input type="checkbox"/> Warrenton Hammond <input type="checkbox"/> NWRESD (SS)	<input type="checkbox"/> Clatskanie <input type="checkbox"/> Rainier (paperwork) <input type="checkbox"/> St. Helens <input type="checkbox"/> Sauvie Island <input type="checkbox"/> Scappoose <input type="checkbox"/> Vernonia <input type="checkbox"/> NWRESD (SS)	<input type="checkbox"/> MESD (Albany –in Linn Co) <input type="checkbox"/> Cascade <input type="checkbox"/> Gervais <input type="checkbox"/> Jefferson <input type="checkbox"/> Mt. Angel <input type="checkbox"/> North Marion <input type="checkbox"/> North Santiam <input type="checkbox"/> Silver Falls <input type="checkbox"/> St. Paul <input type="checkbox"/> WESD
Multnomah County	Polk County	Tillamook County	Yamhill County
<input type="checkbox"/> Corbett <input type="checkbox"/> Gresham-Barlow (SS) <input type="checkbox"/> Riverdale (SS) <input type="checkbox"/> MESD	<input type="checkbox"/> Dallas <input type="checkbox"/> Falls City <input type="checkbox"/> Perrydale <input type="checkbox"/> Willamina <input type="checkbox"/> WESD	<input type="checkbox"/> NWRESD (SS)	<input type="checkbox"/> Amity <input type="checkbox"/> Dayton <input type="checkbox"/> McMinnville <input type="checkbox"/> Sheridan <input type="checkbox"/> Yamhill-Carlton (SS) <input type="checkbox"/> WESD
		Washington County	
		<input type="checkbox"/> Forest Grove (pg 2 I-9) <input type="checkbox"/> NWRESD (SS)	
Subjects you DO wish to work in	→ NOT		

For Office Use Only Below This Point

ID# _____	Already have an Aesop profile? <input type="checkbox"/>	6 digit Aesop Pin# _____
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Teacher ___ / Ed Asst. ___ / ASL ___ / Custodial ___ / *Food Service ___ / Clerical ___ / SPED ___

*Requires a Food Handlers Card

Grades: EI ___ K-5 ___ 6-8 ___ 9-12 ___

<input type="checkbox"/> I-9 (FG pg 2 I-9?)	<input type="checkbox"/> W-4	<input type="checkbox"/> License (licensed only)	<input type="checkbox"/> CHV (Classified only)
<input type="checkbox"/> Direct Deposit	<input type="checkbox"/> Emergency Contact	<input type="checkbox"/> EEOC	<input type="checkbox"/> PERS
<input type="checkbox"/> 403 (B) & 457 (b)	<input type="checkbox"/> Health Coverage	<input type="checkbox"/> Oregon Sick Time	<input type="checkbox"/> CRIS
<input type="checkbox"/> HB2062 1 2 3	<input type="checkbox"/> Rainier Paperwork?	<input type="checkbox"/> PSW	<input type="checkbox"/> Application
<input type="checkbox"/> Photo			

Date: _____ Personnel Signature: _____



Employment Eligibility Verification

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

USCIS
Form I-9
OMB No. 1615-0047
Expires 03/31/2016

▶ **START HERE.** Read instructions carefully before completing this form. The instructions must be available during completion of this form.
ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers **CANNOT** specify which document(s) they will accept from an employee. The refusal to hire 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 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		E-mail Address			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):

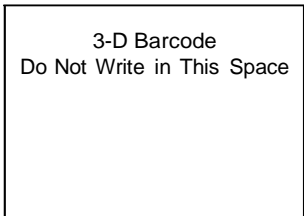
- A citizen of the United States
- A noncitizen national of the United States (See instructions)
- A lawful permanent resident (Alien Registration Number/USCIS Number): _____
- An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy) _____. Some aliens may write "N/A" in this field. (See instructions)

For aliens authorized to work, provide your Alien Registration Number/USCIS Number OR Form I-94 Admission Number:

1. Alien Registration Number/USCIS Number: _____

OR

2. Form I-94 Admission Number: _____



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

Foreign Passport Number: _____

Country of Issuance: _____

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

Signature of Employee:	Date (mm/dd/yyyy):
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Preparer and/or Translator Certification (To be completed and signed if Section 1 is prepared by a person other than the employee.)

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

Signature of Preparer or Translator:		Date (mm/dd/yyyy):	
Last Name (Family Name)		First Name (Given Name)	
Address (Street Number and Name)		City or Town	State Zip Code



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	LIST B Documents that Establish Identity	LIST C Documents that Establish Employment Authorization	
R	AND		
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 2. ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address 3. School ID card with a photograph 4. Voter's registration card 5. U.S. Military card or draft record 6. Military dependent's ID card 7. U.S. Coast Guard Merchant Mariner Card 8. Native American tribal document 9. Driver's license issued by a Canadian government authority 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	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. Certification of Birth Abroad issued by the Department of State (Form FS-545) 3. Certification of Report of Birth issued by the Department of State (Form DS-1350) 4. Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal 5. Native American tribal document 6. U.S. Citizen ID Card (Form I-197) 7. Identification Card for Use of Resident Citizen in the United States (Form I-179) 8. Employment authorization document issued by the Department of Homeland Security	
2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)			
3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa			
4. Employment Authorization Document that contains a photograph (Form I-766)			
5. For a nonimmigrant alien authorized to work for a specific employer because of his or her status: 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.			
			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

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

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

Form W-4 (2016)

Purpose. Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay. Consider completing a new Form W-4 each year and when your personal or financial situation changes.

Exemption from withholding. If you are exempt, complete **only** lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2016 expires February 15, 2017. See Pub. 505, Tax Withholding and Estimated Tax.

Note: If another person can claim you as a dependent on his or her tax return, you cannot claim exemption from withholding if your income exceeds \$1,050 and includes more than \$350 of unearned income (for example, interest and dividends).

Exceptions. An employee may be able to claim exemption from withholding even if the employee is a dependent, if the employee:

- Is age 65 or older,
- Is blind, or
- Will claim adjustments to income; tax credits; or itemized deductions, on his or her tax return.

The exceptions do not apply to supplemental wages greater than \$1,000,000.

Basic instructions. If you are not exempt, complete the **Personal Allowances Worksheet** below. The worksheets on page 2 further adjust your withholding allowances based on itemized deductions, certain credits, adjustments to income, or two-earners/multiple jobs situations.

Complete all worksheets that apply. However, you may claim fewer (or zero) allowances. For regular wages, withholding must be based on allowances you claimed and may not be a flat amount or percentage of wages.

Head of household. Generally, you can claim head of household filing status on your tax return only if you are unmarried and pay more than 50% of the costs of keeping up a home for yourself and your dependent(s) or other qualifying individuals. See Pub. 501, Exemptions, Standard Deduction, and Filing Information, for information.

Tax credits. You can take projected tax credits into account in figuring your allowable number of withholding allowances. Credits for child or dependent care expenses and the child tax credit may be claimed using the **Personal Allowances Worksheet** below. See Pub. 505 for information on converting your other credits into withholding allowances.

Nonwage income. If you have a large amount of nonwage income, such as interest or dividends, consider making estimated tax payments using Form 1040-ES, Estimated Tax for Individuals. Otherwise, you may owe additional tax. If you have pension or annuity income, see Pub. 505 for find out if you should adjust your withholding on Form W-4 or W-4P.

Two earners or multiple jobs. If you have a working spouse or more than one job, figure the total number of allowances you are entitled to claim on all jobs using worksheets from only one Form W-4. Your withholding usually will be most accurate when all allowances are claimed on the Form W-4 for the highest paying job and zero allowances are claimed on the others. See Pub. 505 for details.

Nonresident alien. If you are a nonresident alien, see Notice 1392, Supplemental Form W-4 Instructions for Nonresident Aliens, before completing this form.

Check your withholding. After your Form W-4 takes effect, use Pub. 505 to see how the amount you are having withheld compares to your projected total tax for 2016. See Pub. 505, especially if your earnings exceed \$130,000 (Single) or \$180,000 (Married).

Future developments. Information about any future developments affecting Form W-4 (such as legislation enacted after we release it) will be posted at www.irs.gov/w4.

Personal Allowances Worksheet (Keep for your records.)

A	Enter "1" for yourself if no one else can claim you as a dependent	A	<u> </u>			
B	Enter "1" if: <table border="0" style="display: inline-table; vertical-align: middle;"> <tr> <td style="font-size: 3em; vertical-align: middle;">{</td> <td style="padding: 0 10px;"> <ul style="list-style-type: none"> • You are single and have only one job; or • You are married, have only one job, and your spouse does not work; or • Your wages from a second job or your spouse's wages (or the total of both) are \$1,500 or less. </td> <td style="font-size: 3em; vertical-align: middle;">}</td> </tr> </table>	{	<ul style="list-style-type: none"> • You are single and have only one job; or • You are married, have only one job, and your spouse does not work; or • Your wages from a second job or your spouse's wages (or the total of both) are \$1,500 or less. 	}	B	<u> </u>
{	<ul style="list-style-type: none"> • You are single and have only one job; or • You are married, have only one job, and your spouse does not work; or • Your wages from a second job or your spouse's wages (or the total of both) are \$1,500 or less. 	}				
C	Enter "1" for your spouse . But, you may choose to enter "-0-" if you are married and have either a working spouse or more than one job. (Entering "-0-" may help you avoid having too little tax withheld.)	C	<u> </u>			
D	Enter number of dependents (other than your spouse or yourself) you will claim on your tax return	D	<u> </u>			
E	Enter "1" if you will file as head of household on your tax return (see conditions under Head of household above)	E	<u> </u>			
F	Enter "1" if you have at least \$2,000 of child or dependent care expenses for which you plan to claim a credit (Note: Do not include child support payments. See Pub. 503, Child and Dependent Care Expenses, for details.)	F	<u> </u>			
G	Child Tax Credit (including additional child tax credit). See Pub. 972, Child Tax Credit, for more information. • If your total income will be less than \$70,000 (\$100,000 if married), enter "2" for each eligible child; then less "1" if you have two to four eligible children or less "2" if you have five or more eligible children. • If your total income will be between \$70,000 and \$84,000 (\$100,000 and \$119,000 if married), enter "1" for each eligible child	G	<u> </u>			
H	Add lines A through G and enter total here. (Note: This may be different from the number of exemptions you claim on your tax return.) ▶ H	H	<u> </u>			

For accuracy, **complete all worksheets that apply.**

{	<ul style="list-style-type: none"> • If you plan to itemize or claim adjustments to income and want to reduce your withholding, see the Deductions and Adjustments Worksheet on page 2. • If you are single and have more than one job or are married and you and your spouse both work and the combined earnings from all jobs exceed \$50,000 (\$20,000 if married), see the Two-Earners/Multiple Jobs Worksheet on page 2 to avoid having too little tax withheld. • If neither of the above situations applies, stop here and enter the number from line H on line 5 of Form W-4 below. 	}
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Separate here and give Form W-4 to your employer. Keep the top part for your records.

Form W-4 Department of the Treasury Internal Revenue Service	<h2 style="margin: 0;">Employee's Withholding Allowance Certificate</h2> <p style="margin: 0;">▶ Whether you are entitled to claim a certain number of allowances or exemption from withholding is subject to review by the IRS. Your employer may be required to send a copy of this form to the IRS.</p>	OMB No. 1545-0074 <h1 style="margin: 0;">2016</h1>
1 Your first name and middle initial	Last name	2 Your social security number
Home address (number and street or rural route)		3 <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Married, but withhold at higher Single rate. Note: If married, but legally separated, or spouse is a nonresident alien, check the "Single" box.
City or town, state, and ZIP code		4 If your last name differs from that shown on your social security card, check here. You must call 1-800-772-1213 for a replacement card. ▶ <input type="checkbox"/>
5 Total number of allowances you are claiming (from line H above or from the applicable worksheet on page 2)		5 <u> </u>
6 Additional amount, if any, you want withheld from each paycheck		6 \$ <u> </u>
7 I claim exemption from withholding for 2016, and I certify that I meet both of the following conditions for exemption. • Last year I had a right to a refund of all federal income tax withheld because I had no tax liability, and • This year I expect a refund of all federal income tax withheld because I expect to have no tax liability. If you meet both conditions, write "Exempt" here ▶		7 <u> </u>
Under penalties of perjury, I declare that I have examined this certificate and, to the best of my knowledge and belief, it is true, correct, and complete.		
Employee's signature (This form is not valid unless you sign it.) ▶		Date ▶
8 Employer's name and address (Employer: Complete lines 8 and 10 only if sending to the IRS.)	9 Office code (optional)	10 Employer identification number (EIN)

Deductions and Adjustments Worksheet

Note: Use this worksheet *only* if you plan to itemize deductions or claim certain credits or adjustments to income.

- 1 Enter an estimate of your 2016 itemized deductions. These include qualifying home mortgage interest, charitable contributions, state and local taxes, medical expenses in excess of 10% (7.5% if either you or your spouse was born before January 2, 1952) of your income, and miscellaneous deductions. For 2016, you may have to reduce your itemized deductions if your income is over \$311,300 and you are married filing jointly or are a qualifying widow(er); \$285,350 if you are head of household; \$259,400 if you are single and not head of household or a qualifying widow(er); or \$155,650 if you are married filing separately. See Pub. 505 for details 1 \$ _____
- 2 Enter: { \$9,300 if head of household } 2 \$ _____
- 3 **Subtract** line 2 from line 1. If zero or less, enter “-0-” 3 \$ _____
- 4 Enter an estimate of your 2016 adjustments to income and any additional standard deduction (see Pub. 505) 4 \$ _____
- 5 **Add** lines 3 and 4 and enter the total. (Include any amount for credits from the *Converting Credits to Withholding Allowances for 2016 Form W-4* worksheet in Pub. 505.) 5 \$ _____
- 6 Enter an estimate of your 2016 nonwage income (such as dividends or interest) 6 \$ _____
- 7 **Subtract** line 6 from line 5. If zero or less, enter “-0-” 7 \$ _____
- 8 **Divide** the amount on line 7 by \$4,050 and enter the result here. Drop any fraction 8 _____
- 9 Enter the number from the **Personal Allowances Worksheet**, line H, page 1 9 _____
- 10 **Add** lines 8 and 9 and enter the total here. If you plan to use the **Two-Earners/Multiple Jobs Worksheet**, also enter this total on line 1 below. Otherwise, **stop here** and enter this total on Form W-4, line 5, page 1 10 _____

Two-Earners/Multiple Jobs Worksheet (See *Two earners or multiple jobs* on page 1.)

Note: Use this worksheet *only* if the instructions under line H on page 1 direct you here.

- 1 Enter the number from line H, page 1 (or from line 10 above if you used the **Deductions and Adjustments Worksheet**) 1 _____
 - 2 Find the number in **Table 1** below that applies to the **LOWEST** paying job and enter it here. **However**, if you are married filing jointly and wages from the highest paying job are \$65,000 or less, do not enter more than “3” 2 _____
 - 3 If line 1 is **more than or equal to** line 2, subtract line 2 from line 1. Enter the result here (if zero, enter “-0-”) and on Form W-4, line 5, page 1. **Do not** use the rest of this worksheet 3 _____
- Note:** If line 1 is **less than** line 2, enter “-0-” on Form W-4, line 5, page 1. Complete lines 4 through 9 below to figure the additional withholding amount necessary to avoid a year-end tax bill.
- 4 Enter the number from line 2 of this worksheet 4 _____
 - 5 Enter the number from line 1 of this worksheet 5 _____
 - 6 **Subtract** line 5 from line 4 6 _____
 - 7 Find the amount in **Table 2** below that applies to the **HIGHEST** paying job and enter it here 7 \$ _____
 - 8 **Multiply** line 7 by line 6 and enter the result here. This is the additional annual withholding needed 8 \$ _____
 - 9 Divide line 8 by the number of pay periods remaining in 2016. For example, divide by 25 if you are paid every two weeks and you complete this form on a date in January when there are 25 pay periods remaining in 2016. Enter the result here and on Form W-4, line 6, page 1. This is the additional amount to be withheld from each paycheck 9 \$ _____

Table 1

Table 2

Married Filing Jointly		All Others		Married Filing Jointly		All Others	
If wages from LOWEST paying job are—	Enter on line 2 above	If wages from LOWEST paying job are—	Enter on line 2 above	If wages from HIGHEST paying job are—	Enter on line 7 above	If wages from HIGHEST paying job are—	Enter on line 7 above
\$0 - \$6,000	0	\$0 - \$9,000	0	\$0 - \$75,000	\$610	\$0 - \$38,000	\$610
6,001 - 14,000	1	9,001 - 17,000	1	75,001 - 135,000	1,010	38,001 - 85,000	1,010
14,001 - 25,000	2	17,001 - 26,000	2	135,001 - 205,000	1,130	85,001 - 185,000	1,130
25,001 - 27,000	3	26,001 - 34,000	3	205,001 - 360,000	1,340	185,001 - 400,000	1,340
27,001 - 35,000	4	34,001 - 44,000	4	360,001 - 405,000	1,420	400,001 and over	1,600
35,001 - 44,000	5	44,001 - 75,000	5	405,001 and over	1,600		
44,001 - 55,000	6	75,001 - 85,000	6				
55,001 - 65,000	7	85,001 - 110,000	7				
65,001 - 75,000	8	110,001 - 125,000	8				
75,001 - 80,000	9	125,001 - 140,000	9				
80,001 - 100,000	10	140,001 and over	10				
100,001 - 115,000	11						
115,001 - 130,000	12						
130,001 - 140,000	13						
140,001 - 150,000	14						
150,001 and over	15						

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 who claims no withholding allowances; 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.

Cascade Education Alliance
Direct Deposit Agreement Form (Employee)

Employee ID # _____

First Name:	Last Name:

Type of Action <input type="checkbox"/> New <input type="checkbox"/> Add/Change <input type="checkbox"/> Use my Payroll Information
Direct Deposit for: <input type="checkbox"/> Payroll <input type="checkbox"/> Accounts Payable Payment <input type="checkbox"/> Both

Authorization Agreement

I hereby authorize the **Cascade Technology Alliance and all its affiliated school districts** to initiate automatic deposits to my account at the financial institution named below. I also authorize said districts to make withdrawals from this account in the event that a credit entry is made in error.

Further, I agree not to hold **Cascade Technology Alliance and all its affiliated school districts** responsible for any delay or loss of funds due to incorrect or incomplete information supplied by me or by my financial institution or due to an error on the part of my financial institution in depositing fund to my account.

This agreement will remain in effect until the **Cascade Technology Alliance** receives a written notice of cancellation from me or my financial institution, or until I submit a new direct deposit form to the Fiscal Service Department.

Primary Account Information	
Name of Financial Institution:	Amount:
Type of Account: <input type="checkbox"/> Checking <input type="checkbox"/> Savings	

Secondary Account Information	
Name of Financial Institution:	Amount:
Type of Account: <input type="checkbox"/> Checking <input type="checkbox"/> Savings	

Signature	
Authorized Signature (Primary):	Date:
Authorized Signature (Joint:)	Date:

PLEASE TAPE VOIDED CHECK HERE

PHYSICAL VOIDED CHECK MUST BE TURNED IN WITH THE FORM OR THE ACCOUNT WILL NOT BE SET UP.

Fiscal Department Use Only	
Payroll - Entered By:	Date:
Accounts Payable- Entered By:	Date:

*****SUBSTITUTES PLEASE FILL THIS PORTION OUT*****

Please indicate how you would like to receive your Direct Deposit Receipt:
 (*only if available, districts who do not email receipts will mail receipts instead)

___ I would like a paper copy of my Direct Deposit Receipt sent to me

___ I would like my Direct Deposit Receipt emailed* to the following address:

_____@_____

EMERGENCY CONTACT INFORMATION

Occasionally there is a need to contact someone, whom you authorize, in a non-emergency situation. This information will be provided the utmost level of confidentiality. It will be filed in the Human Resources Department and will be accessed in emergency situations only.

It is the policy of the district to call 911 in any serious emergency.

Name: _____ Date: _____
Address: _____ City: _____ State: _____
Zip: _____ Home Phone: _____ Cell Phone: _____

Please Number the contacts in order of preference.

Contact: _____ Phone: _____

Relationship: _____

Contact: _____ Phone: _____

Relationship: _____

Hospital Preference: _____

Insurance Company: _____

Group/ID Number: _____ Phone: _____

Special Information or Instructions: _____

I hereby authorize that the appropriate steps be taken in case of an emergency.

Signed by

Date

Federal Race and Ethnicity Reporting

Name: _____

Question # 1:

Are you Latino or Hispanic? Yes No

All persons descended from a Spanish-speaking country of origin in North, Central or South America, regardless of race or original language, should answer yes. All persons answering YES to this first question will be reported as a Latino student or staff member, regardless of their answer to the race question below, which all are required to answer.

Question #2:

Please choose one **or** more race:

- American Indian or Alaska Native
A person having origins in any of the original peoples of North, Central or South America, including Mexico, who maintains tribal affiliation or community attachment

- Asian
A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent

- Black or African American
A person having origins in any of the original peoples of the Black racial groups of Africa

- Native Hawaiian or Other Pacific Islander
A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands

- White
A person having origins in any of the original peoples of Europe, the Middle East, or North Africa

In order for these new guidelines to best reflect the identities of our communities it is important to understand the way the new categories work. Those answering “yes” to the Latino question will be reported in the Latino category regardless of their answer to the race question. Please be thoughtful about your identity when choosing the appropriate category. With the exception of Latinos, all those who choose more than one race will be reported as “multi-racial” in our data systems, even though it is not a self-reported category option.

If we do not receive self-identification from a staff member federal law requires that the district designate a different staff person to choose one or more categories based on prior knowledge and observation; this practice is known as Observer Identification. We firmly believe **self-identification** is preferable, but are required to implement **Observer Identification** as a last resort to complete a record.

Name (Print): _____

The IRS requires employers to remind their employees annually to review and make any necessary changes to their W-4 (Employee's Withholding Allowance Certificate). This review will help you determine if your filing status and/or number of withholding allowances will need to change for the new tax year.

---The following IRS resources will help you determine whether you need to update your W-4 tax information.

- IRS Withholding Calculator - <http://www.irs.gov/Individuals/IRS-Withholding-Calculator>
- Publication 505 - Tax Withholding and Estimated Tax - <http://www.irs.gov/pub/irs-pdf/p505.pdf>
- Also see Publication 213 for reasons to review your W-4 - <http://www.irs.gov/pub/irs-pdf/p213.pdf>

Other Important Reminders

---Use your latest pay stub to review your personal information.

- Verify that the spelling and format of your name matches exactly the spelling on your social security card. Please notify Human Resources if this information is incorrect.
- Confirm that your mailing address is correct. This will help ensure the timely receipt of your W-2 and other important payroll and benefit information.

2016 403(b) TSA Plan Announcement

Supplemental Retirement Saving Opportunity - The 403(b) TSA Plan

Your Employer offers an excellent program through which you may contribute a portion of your current income into supplemental retirement savings accounts. Your Employer's supplemental retirement savings program is offered under Section 403(b) of the Internal Revenue Code and is called the Tax-Sheltered Annuity Plan ("TSA Plan").

All part-time and full-time employees are eligible to contribute to the TSA Plan.

You may begin participating in the TSA Plan at any time, by first establishing an investment account with an approved investment provider, and then completing a salary reduction agreement, signing it, and submitting it to your payroll office.

In addition to "traditional" pre-tax 403(b) supplemental retirement savings opportunities your employer plan offers after-tax Roth 403(b) retirement savings opportunities. Roth contributions and attributable earnings must be maintained in separate designated Roth accounts.

Contribution Limits for 2016

The basic elective deferral limit for 2016 is the **lesser** of \$18,000 or 100% of your compensation.

If your 50th birth date occurs on or before December 31, 2016, you are eligible to defer an additional \$6,000, provided your compensation is large enough to allow the extra deferral.

Finally, if you will have at least 15 years of full-time equivalent service with your current Employer by December 31, 2016, then you may be eligible to contribute up to an additional \$3,000 during 2016. If you are planning to make contributions to utilize this catch-up feature, please contact CCC to confirm your maximum allowable contributions for 2016.

Plan Information Is Available on the Web

Comprehensive information about your Employer's TSA Plan is available on the web at www.ncompliance.com, including enrollment procedures, a salary reduction agreement form, Vendor information, transaction information, and educational materials. If you are starting contributions to a new Vendor, you must provide documentation that you have established an account with the Vendor. You may increase, decrease, or stop contributions to the TSA Plan or change the Vendor receiving contributions at any time, by submitting a new salary reduction agreement. Educational information is available on our website to make it easy for you to learn more about supplemental retirement plans and retirement readiness. We encourage you to explore this information at www.ncompliance.com/education.aspx.

Participant Responsibilities

When contributing to your employer-sponsored supplemental retirement savings plan, it is important that you monitor your account activity regularly for accuracy (e.g., deposits of your contributions). If you believe that a problem may exist, please contact the Third Party Administrator (see contact information below) and/or your employer immediately.

Additional Information Available from Third Party Administrator

Your Employer has adopted the services of Carruth Compliance Consulting, Inc. (CCC), an independent third party administrator, to provide compliance and administration services. For questions regarding your Employer's TSA Plan please contact CCC at:

Carruth Compliance Consulting, Inc.
E-mail: cccinfo@ncompliance.com
Phone: 503-968-8961

11515 SW Durham Road, Suite E-10
Tigard, OR 97224
Toll-Free: 877-222-3090

Signature: _____ Date: _____

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Key parts of the Affordable Care Act, also known as the health care reform law, go into effect January 1, 2014. When this happens, there will be a new way to buy health insurance: the Health Insurance Marketplace (the "Marketplace"). In Oregon, this new option is called Cover Oregon. To assist you as you evaluate options for you and your family, this notice provides some basic information about the Marketplace.

Why Are You Providing This Information?

Starting January 1, 2014, the health care reform law will require almost all Americans to have health care coverage. Most U.S. employers are required to send this notice to employees to raise awareness of the new Marketplace and to help them understand how having access to a health care plan available through an employer may limit their eligibility for tax credits in the Marketplace.

What Is the Health Insurance Marketplace?

The Marketplace is designed to help individuals find health insurance that meets their needs and fits their budget. It offers "one-stop shopping" to find and compare private health insurance options. All U.S. citizens and legal residents will have access to individual health insurance policies through the Marketplace in their state for plan years starting January 1, 2014.

Some individuals may also be eligible for a new kind of tax credit that lowers their monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins October 2013 for coverage starting January 1, 2014.

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

You will likely find more affordable coverage through a health plan available through an employer, if applicable, or through your spouse's employer plan, if available, or through your parent's employer plan (if you are under the age of 26).

Some people who do not have access to affordable, minimum value health care coverage through their employer may be eligible for a federal subsidy to make buying insurance through the Marketplace more affordable. The savings these individuals would be eligible for depends on household income.

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

Yes. Individuals who have health coverage available through their employer that meets certain standards are not eligible for a tax credit through the Marketplace and may wish to enroll in their employer's health plan. Some people may be eligible for a tax credit that lowers their monthly premiums or a reduction in certain cost-sharing, if their employer does not offer coverage at all or does not offer coverage that meets certain standards. If an employee doesn't have a health plan option available to him or her through their employer where the cost of the plan for employee-only coverage is less than 9.5 percent of the employee's household income for the year, or if the coverage the employer provides does not meet the "minimum value" standard set by the health care reform law, an employee may be eligible for a tax credit.

Initial: _____

New Health Insurance Marketplace Coverage Options and Your Health Coverage

What If I'm Not Eligible for My Employer's Health Plans?

If you are not eligible for a health plan through an employer, or lose eligibility for health coverage through your employer, you may wish to first consider other group health plan options available to you, such as coverage through your spouse's employer plan, or your parent's employer plan (if you are under age 26). However, anytime after January 1, 2014, you should also consider your state's Marketplace. Enrollment in the Marketplace will begin in October 2013 for coverage beginning in January 2014.

If you decide to enroll through the Marketplace, you will need to provide the Marketplace with some information about your employer and the health plans available through an employer. **Note:** If you purchase a health plan through the Marketplace instead of accepting health coverage offered through your employer, you will lose your employer benefit contribution, if applicable. Another point to consider is that contributions made by employers toward health coverage, as well as your employee contribution toward employer-offered coverage, are 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 health plans available through the Marketplace in Oregon, visit the Cover Oregon website at: www.CoverOregon.com. If you reside outside of Oregon, you can get more information about the Marketplace in your state of residence by going to www.HealthCare.gov.

Electronic Notification

Future information or updates on the Health Insurance Marketplace will be provided electronically through the email address provided below. If you DO NOT wish to receive updates electronically please indicate consent below. You can withdraw your consent at any time by contacting the CTA SubDesk by phone, email, or mail at no charge. Please note that if you opt to receive a paper version of an electronically available document there will be a charge of \$2.50 to cover printing and mailing.

- I **DO** consent to receive Health Insurance Marketplace updates electronically.
- I **DO NOT** consent to receive Health Insurance Marketplace updates electronically.

Name: _____

Signature: _____ Date: _____

Email Address: _____

Oregon Sick Time Law

Effective January 1, 2016 the State of Oregon has implemented the Oregon Sick Time Law.

REQUIREMENTS OF OREGON'S SICK TIME LAW

Effective January 1, 2016, employers that employ employees in the state of Oregon are required to implement sick time policies and provide sick time to employees. Employers are also required to provide employees with a notice of the law's provisions. This notice is intended to summarize the major provisions of the law, but should not be relied upon as a full and complete summary of the law. The full text of the law and administrative rules adopted by the bureau are available at www.oregon.gov/boli.

How much sick time does the law require? Employees begin accruing sick time on the first day of employment and earn one (1) hour of sick time for every 30 hours worked or 1 1/3 hours for every 40 hours worked. Employees may use accrued sick time on the 91st calendar day of employment and may use sick time as it is accrued. Employers may choose to simply give employees ("front load") 40 hours of sick time at the beginning of the year rather than track the number of sick time hours accrued. Employers may also select the 12-month period to be used as the designated "year", e.g., calendar year, fiscal year, employee anniversary date, etc. Employees may carry over up to 40 hours of unused sick time from one year to the next; however, employers may adopt policies that limit employees to accruing no more than 80 hours of sick time or using no more than 40 hours of sick time in a year. Paid time off (PTO) policies that include time off for other purposes (such as vacation and other personal time off) comply with the sick time law as long as the policy is substantially equivalent to or more generous than the requirements of the law. "Substantially equivalent" means that employees are allowed to use at least the same number of hours for the same purposes under the same or more generous rules as outlined in this notice. Employees must use accrued sick time in hourly increments unless to do so would pose an undue hardship to the employer, in which case the employer may require sick time to be taken in minimum increments of four hours if the employer allows employees to use at least 56 hours of paid leave per year for absences covered by this law.

When must sick time be paid? Employers with 10 or more employees in the state (6 or more if the employer maintains a location in Portland) must pay employees for sick time taken at the employee's regular rate of pay. All other employers must provide unpaid sick time. The number of all employees employed by the employer in Oregon must be counted – including fulltime, part-time and temporary employees.

Initials: _____

Oregon Sick Time Law

For what purposes may sick time be used? Employees are entitled to use sick time for the following purposes

- For an employee's or family member's mental or physical illness, injury or health condition or need for medical diagnosis of these conditions or need for preventive medical care.
- To care for an infant or newly adopted child under 18, or for a newly placed foster child under 18, or for a child over 18 if the child is incapable of self-care because of mental or physical disability.
- To care for a family member with a serious health condition.
- To recover from or seek treatment for a serious health condition that renders the employee unable to perform at least one of the essential functions of the employee's job.
- To care for a child of the employee who is suffering from a non-serious illness, injury or condition.
- To deal with the death of a family member by attending the funeral or alternative, making arrangements necessitated by the death of a family member, or grieving the death of a family member.
- To seek medical treatment, legal or law enforcement assistance, remedies to ensure health and safety, or to obtain other services related to domestic violence, sexual assault, harassment or stalking incidents to the employee or employee's minor child or dependent.
- To donate sick time to another employee for qualifying purposes if the employer has a policy allowing such donations.
- For certain public health emergencies including closure by a public official of the employee's place of business, school or place of care of the employee's child, or a determination by a public health authority or health care provider that the presence of the employee or a family member presents a health risk to others.

Notices and Verification: In addition to providing a notice to employees of the requirements of the law, employers are required to provide quarterly notifications to employees of the amounts of accrued and unused sick time. Employers may require employees to provide notices, verifications and certifications for using sick time under certain circumstances. For example, if the need for sick time is foreseeable, employers may require employees to provide up to 10 days' notice of the need to use sick time. Refer to the law and rules for more information.

Discrimination/Retaliation Prohibited: It is unlawful for an employer to deny, interfere with, restrain or fail to pay for sick time to which an employee is entitled; or retaliate or in any way discriminate against an employee because the employee has inquired about the provisions of the law, submitted a request for or taken sick time. Complaints may be filed with the Bureau of Labor and Industries.

Collective Bargaining Agreement Exception: The sick time law does not apply to certain employees who are covered by a collective bargaining agreement, employed through a hiring hall and whose benefits are provided by a joint multi-employer-employee trust or benefit plan.

Provision of this notice to employees complies with the requirement in the sick time law for employers to provide written notice of the requirements of the law to employees. For more information, visit our website at www.oregon.gov/boli, or contact us at [971-673-0761](tel:971-673-0761) or mailb@boli.state.or.us.

Signature: _____

Date: _____

Criminal History Verification of Applicants

Please type or print clearly.

As Appears on Legal Identification

Legal Name: _____
(Last Name) (First Name) (Middle Name)

List Other Names Previously Used: _____
(includes Maiden Name)

Social Security No: _____ DOB: _____ Gender: Male ___ Female ___

Driver License/Identification Card No.: _____ Issue State: _____

Providing your social security number on this form is voluntary. If you choose not to disclose the social security number, this will not be a basis for denial of employment or any rights, services or benefit to which you are otherwise entitled. If you do provide the number the Oregon State Police will use it as an additional identifier to search for any criminal record you may have. Your social security number will be used as stated above. State and federal laws protect the privacy of your records.

Address _____
Street Apt # City State Zip

- A. Have you **EVER** been convicted of a sex-related crime? Yes No
1. If yes, was the conviction in Oregon or another state? Please specify state: _____
2. If yes, did the crime involve force to minors? Yes No
- B. Have you **EVER** been convicted of a crime involving violence or threat of violence? Yes No
1. If yes, was the conviction in Oregon or another state? Please specify state: _____
- C. Have you **EVER** been convicted of a crime involving criminal activity in drugs or alcoholic beverages? Yes No
1. If yes, was the conviction in Oregon or another state? Please specify state: _____
- D. Have you **EVER** been convicted of any other crime except a minor traffic violation?(Includes Traffic Crimes) Yes No
- E. Have you been arrested within the last three years for a crime for which there has not yet been an acquittal or dismissal?
___ Yes No

Advisory: A check of the applicant's criminal history will be made by the Substitute Services to verify the responses to the preceding questions.

I hereby grant to the Substitute Services on behalf of its affiliated districts permission to check civil or criminal records to verify any statement made on this form.

Regardless of whether the applicant grants consent, the Substitute Services will conduct a criminal offender record check of applicants for all prospective school employees and volunteers working with or around children. The applicant is entitled to review his/her criminal history for inaccurate or incomplete information. Discrimination by an employer on the basis of arrest records alone may violate federal civil rights law. The applicant may obtain further information concerning the applicant's rights by contacting the Bureau of Labor and Industries, Civil Rights Division, State office Building, Suite 1070, Portland, Oregon 97323, telephone (503) 731-4075.

I acknowledge reading and the receipt of this notice.

Applicant's Signature: _____

Date: _____

Child Abuse & Sexual Conduct Disclosure Release
 (NWRESD submits this form to previous educational employers)

TO	Educational Employer:	<input type="checkbox"/> No prior Education Provider employment
	City, State, Zip:	
	Attn: Human Resources	
	Fax/Email:	

The applicant named below is under consideration for employment in our district. This individual has previously been employed with your organization. As a former employer, we request you provide the information requested on this form within 20 business days pursuant to ORS 339.374.

APPLICANT:

Last	First	Middle	Previous
Dates of employment:		From:	To:
Position(s) held:			

I authorize you to release to the district listed above, all information related to any substantiated reports of child abuse, sexual conduct, or crimes listed in ORS 342.143. I release the above employer and employees acting on behalf of the employer from any liability for providing information described in this document.

Applicant Signature

Date

This section to be completed by previous employer only.

The employee was was not the subject of a substantiated report of child abuse or sexual conduct related to the applicant's employment with the education provider.

- Dates of any substantiated reports: _____
- Please attach the definitions of child abuse and sexual conduct used by the District when the education provider determined that any reports were substantiated and the standards used by the District to determine whether any reports were substantiated.

 Former Employer Representative Signature

 Date

 Printed Name

 Job Title

Please return completed form to: Substitute Services
 Email: subservices@cascadetech.org
 5825 NE Ray Circle, Hillsboro, OR 97124
 Fax: 503-614-1281 Phone: 866-373-4321