Shasta County Substitute Teacher Consortium Packet

In order to join the Shasta County Substitute Teacher Consortium, the following is required:

- Valid California teaching credential.
- Department of Justice fingerprint clearance for Shasta County Office of Education. Fingerprinting instructions will be provided during your appointment when you turn in this completed packet.
- A negative TB skin test or questionnaire completed within the last 60 days. Tests and questionnaires can be obtained at your doctor’s office, Public Health, or an Urgent Care facility.

Complete the following items included in this packet:

- Consortium Application
- Mandated Training Videos - Complete all four videos prior to appointment
- Employment Eligibility Verification Form I-9
- CALSTRS Permissive Membership
- Statement concerning Social Security - only sign if you are a member of CALSTRS or CALPERS. Or if you elected to join CALSTRS on the prior form.
- Retirement Information
- Mandated Topic sign-off sheet and handbook acknowledgement - The handbook will be provided during your appointment.

Items required for your appointment:

- Valid California teaching credential - (Emergency 30 Day Sub Permit accepted)
- TB results - Please see item above concerning TB requirements
- $50 check, cashiers check, or money order payable to SCOE for fingerprinting fee. The fingerprinting fee for SCOE is waived for the 23/24 school year.
- Identification for the Form I-9 listed above. A list of acceptable identification can be found in the packet.

Once you have completed and checked off ALL of the above items then you are ready to schedule your appointment to turn in your packet. Incomplete packets will be returned to you and your appointment will be rescheduled.

**Appointments are REQUIRED to turn in your packet.**

To schedule your appointment scan the QR code to access our scheduler or call us at 530-225-0200.

***Please remember incomplete packets will be returned to you. You must have all of the items listed above inorder to schedule***
SHASTA COUNTY OFFICE OF EDUCATION
Substitute Teacher Consortium Application

Name: ____________________________________________ Telephone #: __________________________

Address: ________________________________________________

California Credential(s) Held: Type: __________________________ Expires: ______________
Type: __________________________ Expires: ______________

Note: If you do not hold a valid California credential, you will need to submit a credential application packet for certification with this form.

☑ Check grade level areas/programs that you are interested in substitute teaching:

☐ K-3
☐ K-5
☐ Middle School (6-8)
☐ High School (9-12)

Subject Area: ______________________
Subject Area: ______________________

☐ Shasta County Office of Education I wish to sub only for the following district(s)
Shasta County Office of Education

☐ Independent Study
☐ Preschool (ECE units required)
☐ Special Education
☐ Alternative Education:

☐ Juvenile Hall (training required)

** Are you willing to sub in Fall River Joint Unified School District? Yes ___ No ___

☐ Have you ever had a credential suspended or revoked? Yes ___ No ___

If you answer “yes”, you must submit a full explanation using a separate sheet of paper.

EDUCATIONAL BACKGROUND

<table>
<thead>
<tr>
<th>Dates Attended</th>
<th>College/University</th>
<th>Degree</th>
<th>Major</th>
<th>Minor</th>
</tr>
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</table>

TEACHING/WORK EXPERIENCE

<table>
<thead>
<tr>
<th>Dates</th>
<th>Name &amp; Address of Employer</th>
<th>Supervisor &amp; Phone #</th>
<th>Your Position</th>
</tr>
</thead>
<tbody>
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</table>

I hereby certify that all statements made hereon are true and correct to the best of my knowledge and authorize investigation of all statements herein recorded. I release from all liability persons and organizations reporting information required by this application. I understand and agree that misstatements or omission of material facts herein may result in disqualification for or dismissal from employment.

______________________________ (Signature of Applicant) __________________________ (Date)

AN EQUAL OPPORTUNITY EMPLOYER
Mandated Training Videos

- Go online to: https://shastacoe-keenan.safeschools.com/login
  
  o Click on register - which is located below the username box

- Next you will be prompted for a “registration key” code

- Please use key code 48a50f5a and you will be prompted to create an account

- Once your account is created you will see a list of trainings please ONLY complete:
  
  Mandated Reporter: Child Abuse and Neglect
  Sexual Harassment for Non-Managers
  Bloodborne Pathogen Exposure Prevention
  IPM for Teachers and Office Staff

- These videos will take you approximately a total of three hours to complete. Upon completion of each video you will be required to take a short quiz. There is no need to print the certificates, we will look them up during your appointment.
## START HERE: Read instructions carefully before completing this form. The instructions must be available, either in paper or electronically, during completion of this form. Employers are liable for errors in the completion of this form.

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

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

<table>
<thead>
<tr>
<th>Last Name (Family Name)</th>
<th>First Name (Given Name)</th>
<th>Middle Initial</th>
<th>Other Last Names Used (if any)</th>
</tr>
</thead>
<tbody>
<tr>
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</table>

<table>
<thead>
<tr>
<th>Address (Street Number and Name)</th>
<th>Apt. Number</th>
<th>City or Town</th>
<th>State</th>
<th>ZIP Code</th>
</tr>
</thead>
<tbody>
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</table>

<table>
<thead>
<tr>
<th>Date of Birth (mm/dd/yyyy)</th>
<th>U.S. Social Security Number</th>
<th>Employee's E-mail Address</th>
<th>Employee's Telephone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</table>

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

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

- [ ] 1. A citizen of the United States
- [ ] 2. A noncitizen national of the United States *(See instructions)*
- [ ] 3. A lawful permanent resident *(Alien Registration Number/USCIS Number): ____________________________*
- [ ] 4. An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy): ____________________________

Some aliens may write "N/A" in the expiration date field. *(See instructions)*

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

1. Alien Registration Number/USCIS Number: ____________________________

   **OR**

2. Form I-94 Admission Number: ____________________________

   **OR**

3. Foreign Passport Number: ____________________________

   Country of Issuance: ____________________________

Signature of Employee

Today's Date (mm/dd/yyyy)

---

### Preparer and/or Translator Certification
(check one):

- [ ] I did not use a preparer or translator.
- [ ] A preparer(s) and/or translator(s) assisted the employee in completing Section 1.

*(Fields below must be completed and signed when preparers and/or translators assist an employee in completing Section 1.)*

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

<table>
<thead>
<tr>
<th>Signature of Preparer or Translator</th>
<th>Today's Date (mm/dd/yyyy)</th>
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<tr>
<th>Last Name (Family Name)</th>
<th>First Name (Given Name)</th>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Address (Street Number and Name)</th>
<th>City or Town</th>
<th>State</th>
<th>ZIP Code</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</table>
Section 2. Employer or Authorized Representative Review and Verification

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

<table>
<thead>
<tr>
<th>Employee Info from Section 1</th>
<th>List A</th>
<th>OR</th>
<th>List B</th>
<th>AND</th>
<th>List C</th>
</tr>
</thead>
<tbody>
<tr>
<td>Last Name (Family Name)</td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>First Name (Given Name)</td>
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<tr>
<td>M.I.</td>
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<tr>
<td>Citizenship/Immigration Status</td>
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</tr>
</tbody>
</table>

- **List A**
  - Document Title
  - Issuing Authority
  - Document Number
  - Expiration Date (if any) (mm/dd/yyyy)

- **List B**
  - Document Title
  - Issuing Authority
  - Document Number
  - Expiration Date (if any) (mm/dd/yyyy)

- **List C**
  - Document Title
  - Issuing Authority
  - Document Number
  - Expiration Date (if any) (mm/dd/yyyy)

**Additional Information**

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

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

<table>
<thead>
<tr>
<th>Signature of Employer or Authorized Representative</th>
<th>Today’s Date (mm/dd/yyyy)</th>
<th>Title of Employer or Authorized Representative</th>
</tr>
</thead>
<tbody>
<tr>
<td>Last Name of Employer or Authorized Representative</td>
<td>First Name of Employer or Authorized Representative</td>
<td>Employer’s Business or Organization Name</td>
</tr>
<tr>
<td>Employer’s Business or Organization Address (Street Number and Name)</td>
<td>City or Town</td>
<td>State</td>
</tr>
</tbody>
</table>

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

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

- **B. Date of Rehire (if applicable)**
  - Date (mm/dd/yyyy)

- **C. If the employee’s previous grant of employment authorization has expired, provide the information for the document or receipt that establishes continuing employment authorization in the space provided below.**
  - Document Title
  - Document Number
  - Expiration Date (if any) (mm/dd/yyyy)

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

<table>
<thead>
<tr>
<th>Signature of Employer or Authorized Representative</th>
<th>Today’s Date (mm/dd/yyyy)</th>
<th>Name of Employer or Authorized Representative</th>
</tr>
</thead>
</table>
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.

<table>
<thead>
<tr>
<th>LIST A</th>
<th>LIST B</th>
<th>LIST C</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Documents that Establish Both Identity and Employment Authorization</strong></td>
<td><strong>Documents that Establish Identity</strong></td>
<td><strong>Documents that Establish Employment Authorization</strong></td>
</tr>
<tr>
<td>1. U.S. Passport or U.S. Passport Card</td>
<td>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</td>
<td>1. A Social Security Account Number card, unless the card includes one of the following restrictions: (1) NOT VALID FOR EMPLOYMENT</td>
</tr>
<tr>
<td>2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)</td>
<td>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</td>
<td>(2) VALID FOR WORK ONLY WITH INS AUTHORIZATION</td>
</tr>
<tr>
<td>3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa</td>
<td>3. School ID card with a photograph</td>
<td>(3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION</td>
</tr>
<tr>
<td>5. For a nonimmigrant alien authorized to work for a specific employer because of his or her status:</td>
<td>5. U.S. Military card or draft record</td>
<td>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</td>
</tr>
<tr>
<td>b. Form I-94 or Form I-94A that has the following:</td>
<td>7. U.S. Coast Guard Merchant Mariner Card</td>
<td>5. U.S. Citizen ID Card (Form I-197)</td>
</tr>
<tr>
<td>(1) The same name as the passport; and</td>
<td>8. Native American tribal document</td>
<td>6. Identification Card for Use of Resident Citizen in the United States (Form I-179)</td>
</tr>
<tr>
<td>(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.</td>
<td>9. Driver's license issued by a Canadian government authority</td>
<td>7. Employment authorization document issued by the Department of Homeland Security</td>
</tr>
<tr>
<td>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</td>
<td><strong>For persons under age 18 who are unable to present a document listed above:</strong></td>
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<td></td>
<td>11. Clinic, doctor, or hospital record</td>
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Examples of many of these documents appear in the Handbook for Employers (M-274).

Refer to the instructions for more information about acceptable receipts.
Permissive Membership - Instructions

If you are employed to perform creditable service in a position that is excluded from mandatory membership in the CalSTRS' Defined Benefit (DB) Program, you may use this form to elect DB Program membership at any time while employed to perform creditable service.

A permissive election of membership in the DB Program applies to all future creditable service performed for the same or another employer, including any non-member or CalSTRS Cash Balance Benefit (CB) Program service you are currently performing. You may be entitled to elect coverage by the CB Program or California Public Employees' Retirement System (CalPERS) for future eligible service as allowed by law. Please work with your employer if you believe you are entitled to make one of these elections.

A permissive election of membership in the DB Program is irrevocable. Membership may only be cancelled if you terminate all employment to perform creditable service and refund your accumulated retirement contributions from the CalSTRS DB Program.

SECTION 1: EMPLOYEE INFORMATION (TO BE COMPLETED BY EMPLOYEE)

Provide the following information:
- CalSTRS Client ID* or Social Security Number
- Last Name, First Name and Middle Initial
- Mailing Address**, City, State and Zip Code
- Date of Birth
- Email Address
- Telephone Number

*If you have already been employed to perform creditable service you will have a CalSTRS Client ID, even if you were not formerly a member. Please provide your CalSTRS Client ID, if you have one, in lieu of your Social Security Number.

**To establish residency for tax purposes, we ask that you provide a street address. Be sure to include any street, apartment or suite number. If your post office does not deliver mail to your street address, you may enter your box number instead. If you reside outside the United States, use the CITY – STATE – ZIP field to provide your foreign address. If you receive your mail in care of a third party, enter "c/o" followed by the third party's name and address.

SECTION 2: EMPLOYEE ELECTION (TO BE COMPLETED BY EMPLOYEE)

If you want to elect membership in the CalSTRS DB Program:
- Check the appropriate box
- Provide your requested membership date***

***You will begin contributing to the DB Program as of your membership date. Your membership date can be no earlier than the first day of the pay period in which your election is made, or your first day of employment, whichever is later. Work with your employer to select the most beneficial, valid membership date you are eligible for. Electing an invalid membership date will require a revision to your election form and may result in delayed contributions to CalSTRS.

If you do not want to elect membership in the CalSTRS DB Program at this time, check the appropriate box.

SECTION 3: REQUIRED SIGNATURE (TO BE COMPLETED BY EMPLOYEE)

Sign the form and date your signature.
Return the form to your employer.

SECTION 4: EMPLOYEE POSITION INFORMATION (TO BE COMPLETED BY EMPLOYER)

Provide the position hire date – the date in which the employee was hired to perform creditable service in the position they are making this election for. CalSTRS defers to the employer as to the date in which you consider an employee to be hired. Provide the position title – the title of the position the employee is performing creditable service in.

SECTION 5: EMPLOYER INFORMATION AND CERTIFICATION (TO BE COMPLETED BY EMPLOYER)

Verify the employee is eligible for the requested membership date.

Provide the following information:
- The employer (county or district) name
- County and district code
- Name and title of employer official completing the form

Sign the form and date your signature.
Submit the form to CalSTRS and retain a copy.
SUBMIT
This form should be submitted to CalSTRS by the employer. CalSTRS must receive this form within 60 days after the employee’s signature date and, if applicable, prior to the submission of contributions.

Secure Employer Website: Send the completed form to the ES Forms Queue found in the Business Areas dropdown of the Recipient via SEW.

Email to: Submit this form via email to the esforms@calstrs.com mailbox unless otherwise instructed by your CalSTRS representative. If sending forms to the esforms@calstrs.com mailbox, please remove all Social Security numbers and only provide the Client ID where applicable.

Mail to: CalSTRS
P.O. Box 15275, MS 17
Sacramento, CA 95851-0275

QUESTIONS
Employee – contact your employer

Employer – contact CalSTRS Employer Help
PERMISSIVE MEMBERSHIP ELECTION AND/OR ACKNOWLEDGEMENT OF RECEIPT
OF CALSTRS DEFINED BENEFIT PROGRAM MEMBERSHIP INFORMATION

This form is used to permissively elect membership in the CalSTRS Defined Benefit Program and/or to acknowledge receipt of information provided by an employer about the right to elect membership in the CalSTRS Defined Benefit Program. Please read all instructions before completing the form.

Section 1: Employee Information (to be completed by employee)
Provide either your CalSTRS Client ID or Social Security number.

CLIENT ID

SOCIAL SECURITY NUMBER

LAST NAME

FIRST NAME

MI

ADDRESS (number, street, apt or suite no.)

CITY

STATE

ZIP CODE

DATE OF BIRTH (MM/DD/YYYY)

EMAIL ADDRESS

TELEPHONE

Section 2: Employee Election (to be completed by employee)
Check One:

☐ I elect membership in the CalSTRS Defined Benefit Program as of: MEMBERSHIP DATE (MM/DD/YYYY)**

I understand this election applies to all future creditable service performed for any current or future employer unless another election is made as allowed by law. I understand my membership is irrevocable and may only be cancelled by terminating all employment to perform creditable service and receiving a refund of my accumulated retirement contributions from the CalSTRS Defined Benefit Program.

**Membership Date may be no earlier than the first day of the pay period in which the election is made, or the first day of employment, whichever is later. Please work with your employer to select the most beneficial, valid membership date.

☐ I decline membership in the CalSTRS Defined Benefit Program at this time

I understand that I can elect membership in the CalSTRS Defined Benefit Program at any time while I am employed to perform creditable service.
Section 3: Required Signature (to be completed by employee)

I certify that I have received information from my employer concerning the CalSTRS Defined Benefit Program and understand the criteria for membership in the program.

I understand it is a crime to fail to disclose a material fact or to make any knowingly false material statement, including a false statement regarding my marital status, for the purpose of using it, or allowing it to be used, to obtain, receive, continue, increase, deny or reduce any benefit administered by CalSTRS and it may result in penalties, including restitution, of up to one year in jail and/or a fine of up to $5,000 (Education Code section 22010). It may also result in any document containing such false representation being voided. I certify under penalty of perjury under the laws of the State of California that the foregoing is true and correct. I understand that perjury is punishable by imprisonment for up to four years (Penal Code section 126).

<table>
<thead>
<tr>
<th>EMPLOYEE SIGNATURE</th>
<th>DATE (MM/DD/YYYY)</th>
</tr>
</thead>
</table>

Section 4: Employee Position Information (to be completed by employer)

POSITION TITLE

POSITION HIRE DATE

Section 5: Employer Information and Certification (to be completed by employer)

Required Signature

I certify that the above-named employee was provided information about their right to elect membership in the CalSTRS Defined Benefit Program and, if electing membership, is eligible to elect membership in the CalSTRS Defined Benefit Program as of the membership date provided.

I understand it is a crime to fail to disclose a material fact or to make any knowingly false material statement for the purpose of using it, or allowing it to be used, to obtain, receive, continue, increase, deny or reduce any benefit administered by CalSTRS and it may result in penalties, including restitution, of up to one year in jail and/or a fine of up to $5,000 (Education Code section 22010). It may also result in any document containing such false representation being voided. I certify under penalty of perjury under the laws of the State of California that the foregoing is true and correct. I understand that perjury is punishable by imprisonment for up to four years (Penal Code section 126).

<table>
<thead>
<tr>
<th>EMPLOYER OFFICIAL’S SIGNATURE</th>
<th>DATE (MM/DD/YYYY)</th>
</tr>
</thead>
<tbody>
<tr>
<td>EMPLOYER NAME</td>
<td>COUNTY AND DISTRICT CODE</td>
</tr>
<tr>
<td>EMPLOYER OFFICIAL’S NAME AND TITLE</td>
<td></td>
</tr>
</tbody>
</table>
Statement Concerning Your Employment in a Job Not Covered by Social Security

Employee Name _______________________________________________ Employee ID# ______________________________________

Employer Name _______________________________________________ Employer ID# ______________________________________

Your earnings from this job are not covered under Social Security. When you retire, or if you become disabled, you may receive a pension based on earnings from this job. If you do, and you are also entitled to a benefit from Social Security based on either your own work or the work of your husband or wife, or former husband or wife, your pension may affect the amount of the Social Security benefit you receive. Your Medicare benefits, however, will not be affected. Under the Social Security law, there are two ways your Social Security benefit amount may be affected.

Windfall Elimination Provision
Under the Windfall Elimination Provision, your Social Security retirement or disability benefit is figured using a modified formula when you are also entitled to a pension from a job where you did not pay Social Security tax. As a result, you will receive a lower Social Security benefit than if you were not entitled to a pension from this job. For example, if you are age 62 in 2013, the maximum monthly reduction in your Social Security benefit as a result of this provision is $395.50. This amount is updated annually. This provision reduces, but does not totally eliminate, your Social Security benefit. For additional information, please refer to Social Security Publication, "Windfall Elimination Provision."

Government Pension Offset Provision
Under the Government Pension Offset Provision, any Social Security spouse or widow(er) benefit to which you become entitled will be offset if you also receive a Federal, State or local government pension based on work where you did not pay Social Security tax. The offset reduces the amount of your Social Security spouse or widow(er) benefit by two-thirds of the amount of your pension.

For example, if you get a monthly pension of $600 based on earnings that are not covered under Social Security, two-thirds of that amount, $400, is used to offset your Social Security spouse or widow(er) benefit. If you are eligible for a $500 widow(er) benefit, you will receive $100 per month from Social Security ($500 - $400 = $100). Even if your pension is high enough to totally offset your spouse or widow(er) Social Security benefit, you are still eligible for Medicare at age 65. For additional information, please refer to Social Security Publication, "Government Pension Offset."

For More Information
Social Security publications and additional information, including information about exceptions to each provision, are available at www.socialsecurity.gov. You may also call toll free 1-800-772-1213, or for the deaf or hard of hearing call the TTY number 1-800-325-0778, or contact your local Social Security office.

I certify that I have received Form SSA-1945 that contains information about the possible effects of the Windfall Elimination Provision and the Government Pension Offset Provision on my potential future Social Security Benefits.

Signature of Employee ______________________________________ Date ________________________

Form SSA-1945 (01-2013)
Destroy Prior Editions
Information about Social Security Form SSA-1945 Statement Concerning Your Employment in a Job Not Covered by Social Security

New legislation [Section 419(c) of Public Law 108-203, the Social Security Protection Act of 2004] requires State and local government employers to provide a statement to employees hired January 1, 2005 or later in a job not covered under Social Security. The statement explains how a pension from that job could affect future Social Security benefits to which they may become entitled.

Form SSA-1945, Statement Concerning Your Employment in a Job Not Covered by Social Security, is the document that employers should use to meet the requirements of the law. The SSA-1945 explains the potential effects of two provisions in the Social Security law for workers who also receive a pension based on their work in a job not covered by Social Security. The Windfall Elimination Provision can affect the amount of a worker's Social Security retirement or disability benefit. The Government Pension Offset Provision can affect a Social Security benefit received as a spouse, surviving spouse, or an ex-spouse.

Employers must:

- Give the statement to the employee prior to the start of employment;
- Get the employee’s signature on the form; and
- Submit a copy of the signed form to the pension paying agency.

Social Security will not be setting any additional guidelines for the use of this form.

Copies of the SSA-1945 are available online at the Social Security website, www.socialsecurity.gov/online/ssa-1945.pdf. Paper copies can be requested by email at ofsm.oswm.rqct.orders@ssa.gov or by fax at 410-965-2037. The request must include the name, complete address and telephone number of the employer. Forms will not be sent to a post office box. Also, if appropriate, include the name of the person to whom the forms are to be delivered. The forms are available in packages of 25. Please refer to Inventory Control Number (ICN) 276950 when ordering.
In accordance with the Omnibus Benefit Reform Act, all employees of the Shasta County Office of Education (SCOE), whether employed full-time or part-time, must be offered a retirement program. Please place a checkmark in the box by the appropriate program that applies to your situation.

Please check all the boxes that apply:

**California Public Employees’ Retirement System (CalPERS) Information (classified employee):**

- [ ] I am a current CalPERS member.
- [ ] I am a current employee at another district ____________________________ (district name).
- [ ] I was a member but have withdrawn my contributions ____________________________ (district name).
- [ ] I am a retired CalPERS member. Date of retirement ____________ PLEASE NOTE: California retirement law governs the type of employment you may have with a CalPERS-covered agency after you have retired. You must reinstate from retirement before you go back to work in a permanent position with an employer covered by CalPERS. Temporary employment must not exceed a total of 960 hours for all employers covered by CalPERS in any fiscal year (July 1 through June 30). You cannot be employed by a CalPERS employer for a period of 180 days after your retirement date without reinstating from retirement. Please refer to CalPERS PUB 33, A Guide to CalPERS Employment after Retirement and/or PUB 37, A Guide to CalPERS Reinstatement from Retirement for further information.

- If a new certificated employee has 5 years of CalPERS service credit or if their CalPERS membership is through prior schools employment, you can elect to remain in CalPERS.

**California State Teacher’s Retirement System (CalSTRS) Information (certificated employee):**

- [ ] I am a current CalSTRS member.
- [ ] I am a current certificated employee at another district ____________________________ (district name).
- [ ] I was a member but have withdrawn my contributions ____________________________ (district name).
- [ ] I am a retired CalSTRS member. Date of Retirement ____________ PLEASE NOTE: There are some restrictions regarding Post Retirement Employment in the public school system in California. You cannot be employed by a CalSTRS employer for a period of 180 days after your retirement date without reinstating from retirement. For more information on earnings limitation after retirement, please call CalSTRS at 1-800-228-5453 or visit the website at www.CalSTRS.com.

- If you have ever been a member of CalSTRS and have not withdrawn your contributions (even if you have not taught for several years), you are still a member.

If none of the above retirement systems apply, please initial here ____________.

**Statement Concerning Your Employment in a Job Not Covered by Social Security**

Please read and sign the “Statement Concerning Your Employment in a Job Not Covered by Social Security” (SSA-1945 form). The statement explains how a pension from a retirement system other than Social Security could affect future Social Security benefits to which you may become entitled.

I certify that all information on this form is accurate and true to the best of my knowledge.

______________________________  ______________________________
Signature                        Date

Revised October 2013
Mandated Topic Sign-Off and Substitute Teacher Handbook Acknowledgement

The Shasta County Office of Education has prepared a handbook of information that is provided to all new substitute teachers. This handbook contains important sources of information that you need to read and keep for future reference.

The Substitute Teacher Handbook includes copies of the following policies:

1) Acknowledgement of Employee’s Knowledge of Mandatory Child Abuse Reporting Obligations
2) Sexual Harassment Superintendent Policy and Regulation
3) Drug and Alcohol-Free Workplace Policy
4) Maintaining Appropriate Adult-Student Interactions Policy

I hereby acknowledge that I have read the foregoing statement and have received a copy of the Substitute Teacher Handbook. I understand that the handbook contains important information regarding Child Abuse Reporting Obligations, Sexual Harassment Policy, Drug and Alcohol-Free Workplace Policy, and Appropriate Adult-Student Interactions Policy.

____________________________________  __________________
Substitute Signature                        Date

____________________________________
Substitute Name