APPLICATION CHECKLIST

Interview Date:_____
Time:_____

NAME_____
PHONE #____ _____
ID # (for Union) _____
EMAIL_____
ISNet BADGE Y☐ N☐ #_____
UNION CALL OUT: Y☐ N☐ UNION LOCAL: _____UNION CLASSIFICATION: ____JM, AP

---

1) To ensure a complete application packet is received, check off each item.

HR Documents
_____Application
_____Emergency Contact
_____Background Release
_____Confidentiality Agreement
_____Consent & Release 2810.5 Labor Code Employee Notice
_____COVID-19 Self Cert
_____I9 Homeland Security
_____EPN Authorization
_____MVR Report
_____Driver's License
_____SSN/Birth Cert/Passport
_____Applicant Photo

Payroll Documents
_____W4
_____DE4 CA Tax
_____Direct Deposit

Safety Documents
_____First Aid Cert
_____CPR Cert
_____Flagger Cert
_____Any Additional Safety Certs Provided
_____Photo

Insight Survey
_____Set up new survey on office iPad. If applicant is not available to stay in the office, send survey to their email and instruct them that the survey must be completed before an interview is scheduled.

2) Prepare Packet for Manager
_____Place Admin Checklist, application pages 1 & 2 on top of manila envelope. Place remaining documents in envelope and place the envelope in Manager's box.
_____**Interview Date Mon.**

Area Managers

3) Interview
_____Failed – Advise Admins to shred/delete packet
_____Passed – Begin Physical Requirements Test

4) Complete Physical Requirements Form
_____Failed – Advise Admins to shred/delete packet
_____Passed – Advise Admins to schedule a drug test

***MGR – If a Union sponsorship or request, send ASAP before 2pm (Tue Sac/Wed Mare)**
_____Sent Sponsorship Letter
_____Sent Letter of Request
_____Return Checklist & Packet to Admins
_____Union Notification Received

Administrators

5) Schedule Drug Test
_____Failed – Shred/delete file
_____Passed – Email received From HR

6) Distribute Documents
_____Send complete packet, including Physical Req. Form to HR
_____Send applicable documents to Payroll and Safety

7) Contact Applicant
_____Advise they are a successful candidate
_____Advise an email coming with date & time, itinerary, etc.

8) Orientation Email
_____Email sent to employee HR

APPLICATION COMPLETE

EMPLOYMENT PHYSICAL REQUIREMENTS

Name _____

Date _____

CRITICAL DEMAND	TEST METHOD	SCORE
VISION	Must identify letters on the Vision Board from 20 ft. away. May use aids.	____Pass ____Fail
HEARING	Adequately hear a forced whisper at 5 ft. May use aids.	____ Pass ____Fail
LIFT & CARRY	Lift & carry up to 50 lbs. using either or both hands. Lift the loaded crate from floor to waist height, carry it 10 ft, and return it to the floor. Repeat 5 times.	____Pass ____Fail
BEND & SQUAT	Must be able to bend, squat, and stoop. Demonstrate the ability to "duck walk" for 10 ft., pivot, and return to starting point.	____ Pass ____Fail
PUSH & PULL	Demonstrate ability to push a cart 20 ft. with 50 lbs. of weight added and return 20 to the starting point.	____Pass ____Fail
INTERMITTENT MOVEMENT	Must be able to move intermittently. Observe movement throughout the exam, including walking and posture.	____ Pass ____Fail
GRIP	Using each hand separately demonstrates a simple grip on a heavy tool and a firm grasp of the same device.	____Pass ____Fail

Physical Requirements Exam conducted by

_____

Print name

WOMEN BUSINESS ENTERPRISE

ESTABLISHED 2019

APPLICATION INSTRUCTIONS

Thank you for inquiring about employment with WBE Traffic Control Inc. Please review the Job Description to determine that you meet all the roles, responsibilities, and requirements for the position.

To be considered for employment, you must complete an application and provide the required documentation below. Once completed, return the package in full to one of our field offices. Please note if your application is incomplete or missing documents, it will not be held or considered for review until it is complete.

If the Company is not hiring, you may inquire for the next 30 days. After 30 days, a new application and requirement will be required.

Requirements

- Job Description – Meet all roles, responsibilities, and requirements
- Complete the Application for Employment
- Provide a current driver's license
- Provide a Department of Motor Vehicles online Driver's Record Request report. Please see Motor Vehicle Report Guidelines on the following page.
- Provide a social security card
    - If you do not have your social security card, you may provide a current passport or birth
    - certificate as required by Homeland Security.
- Banking information, including routing number for paycheck direct deposit
- CPR, First Aid, and Flagger certifications

The links below are resources for the DMV Driver's Record Request, CPR, First Aid, and Flagger certifications.

National CPR Foundation
www.nationalcprfoundation.com/courses/standard-cpr-aed-first-aid/
In this CPR and First-Aid Certification Class, you'll learn how to perform CPR, use an AED, and apply First-Aid.

ATTSSA Safter Roads Saves Lives
www.atssa.com

Department of Motor Vehicles
www.dmv.ca.gov

WBE Traffic Control Inc. Field Office Locations

10359 Macready Ave.	343 Waterfront Ave.
Mather, CA 95655	Vallejo, CA 94592

Motor Vehicle Report - Driver Guidelines for Oregon Mutual Insurance Company

If you have any of the below motor vehicle violations within the last **3 years** you will not be an insurable driver through our insurance carrier, Oregon Mutual.

If you are an uninsurable driver WBE cannot move forward with your application.

Major Violations Include (but not limited to):

1. Driving under the influence of drugs or alcohol
2. Road rage
3. Reckless driving, negligent homicide or aggravated assault with a motor vehicle or any criminal conviction
4. Driving while license is suspended
5. Speed contest (racing)
6. Passing school bus with lights flashing for loading or unloading
7. Crossing RR tracks against activated warnings
8. Hit and run accident
9. Speed >15 mph over the limit (general guideline if speed is known)
10. Other violations which show a significant disregard for the safe operation of motor vehicles.
11. Two or more cell phone infractions.

WBE TRAFFIC CONTROL INC.

Job Title:	Traffic Control Flagger	**Job Category:**	Apprentice - Journeyman
Department/Group:	Operations: Field	**Travel Required:**	Yes
Location:	Northern California	**Position Type:**	Full Time
Level/Salary Range:	Determined by Union Wage	**Will Train:**	Yes

Job Description

A dependable, dedicated, and observant person to correctly set up a job location to direct and monitor traffic flow at and around a designated area. Courteously inform motorists and the public of possible detour routes and answer questions. Accurately direct emergency vehicles safely through work zones.

Role and Responsibilities

- Accurately position warning and detour signs, barricades, traffic cones, and equipment per regulations.
- Monitor and direct the traffic flow and emergency vehicles at and around the site.
- Use correct hand signals and signs to direct traffic.
- Communicate clearly using Company call codes with a hand-held device.
- Communicate courteously with the public, coworkers, contractors, inspectors, etc.
- Follow all safety rules/regulations. Immediately inform crew leader of any concern that may affect safety issues.
- Accurately complete timecards, truck inventory, and all required forms.
- Attend all required meetings.

Requirements

- Check each box that you can successfully, competently, and thoroughly complete the following:
  - ☐ Drive long distances.
  - ☐ Stand for long, extended periods.
  - ☐ Move safely over uneven terrain.
  - ☐ Work in extreme and harsh weather conditions day or night.
  - ☐ Lift and carry 50 pounds routinely.
  - ☐ See and hear acutely to respond to dangerous situations.
  - ☐ Wear personal protective gear for extended periods day and or night.
  - ☐ Work as part of a team.
  - ☐ Possess excellent organizational, problem-solving, and observation skills.
  - ☐ Correctly complete daily paperwork.
  - ☐ Successfully complete continuous training promptly.
- Become a union member on or after eight days of employment.
- Pay union initiation fees and reoccurring union dues.
- Obtain an American Traffic Safety Services Association (ATSSA) certification.
- Obtain CPR, First Aid, and Flagger certification.

I acknowledge that I have received, read, and accepted the roles and responsibilities and meet or exceed the position requirements.

Print Name: _____ **Date** _____

Signature: _____

Revised: 10/5/2023

Application for Employment

We are an equal opportunity employer and do not unlawfully discriminate in employment. No question on this application is used for the purpose of limiting or excluding any applicant from consideration for employment on a basis prohibited by local, state, or federal law. Equal access to employment, services, and programs is available to all persons. Those applicants requiring reasonable accommodation to the application and/or interview process should notify a representative of WBE Traffic Control.

Date: _____

Applicant's legal name: _____

Position applied for/or type of work desired: _____

Street address: _____

City: _____State: _____Zip:_____

Telephone number area code: _____Phone number: _____

Email:_____

Driver's license number: _____

Driver's license expiration date: _____

Type of employment desired: Full-Time _____Part-Time _____Temporary _____

Date you will be available to start work: _____

Are you able to meet the roles, responsibilities and requirements on the Job Description? _____

Are you able to meet attendance requirements? _____

Do you have any objection to working overtime? _____

Can you travel and stay overnight when necessary? _____

Have you ever been previously employed by our organization? _____

Can you submit proof of legal employment authorization and identity? _____

How were you referred to WBE? _____

5150 FAIR OAKS BLVD STE 101-362

CARMICHAEL, CA 95608

707-771-5870

WWW.WBETC.COM

Application for Employment

Employment History: Please provide past employment information starting with the most recent.

Employer: _____ Position held: _____

Address: _____

Telephone #: _____ Immediate supervisor and title: _____

Dates employed: from _____ to _____ Salary: _____

Job summary: _____

Reason for leaving: _____

Employer: _____ Position held: _____

Address: _____

Telephone #: _____ Immediate supervisor and title: _____

Dates employed: from _____ to _____ Salary: _____

Job summary: _____

Reason for leaving: _____

Other Skills and Qualifications:
Summarize any job-related training, skills, licenses, certificates, and/or other qualifications:

_____

Educational History:
List school name and location, years completed, course of study, and any degrees earned:
High school: _____
College: _____
Other training: _____

References: List three references, including names, telephone numbers, and years known (do not include relatives or employers) _____

_____

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CARMICHAEL, CA 95608
707-771-5870
WWW.WBETC.COM

Application for Employment

I hereby authorize the potential employer to contact, obtain, and verify the accuracy of information contained in this application from all previous employers, educational institutions, and references. I also hereby release from liability the potential employer and its representatives for seeking, gathering, and using such information to make employment decisions and all other persons or organizations for providing such information.

I understand that any misrepresentation or material omission made by me on this application will be sufficient cause for cancellation of this application or immediate termination of employment if I am employed, whenever it may be discovered.

If I am employed, I acknowledge that there is no specified length of employment, and that this application does not constitute an agreement or contract for employment. Accordingly, either I or the employer can terminate the relationship at will, with or without cause, at any time, so long as there is no violation of applicable federal or state law.

I understand that it is the policy of this organization not to refuse to hire or otherwise discriminate against a qualified individual with a disability because of that person's need for a reasonable accommodation as required by the Americans with Disabilities Act (ADA).

I also understand that if I am employed, I will be required to provide satisfactory proof of identity and legal work authorization within three days of being hired. Failure to submit such proof within the required time shall result in immediate termination of employment.

I represent and warrant that I have read and fully understand the foregoing, and that I seek employment under these conditions.

Applicant signature: _____ Date: _____

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Emergency Information

In Case of Emergency, please notify:

Name: _____

Relationship: _____

Phone Number: _____

Street Address: _____ City: _____

State: _____Zip Code: _____

In Case of Emergency, I authorize contact and information to be released to the person named above.

Employee Name: _____

Employee Signature: _____ Date: _____

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CARMICHAEL, CA 95608
707-771-5870
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Background Release Agreement

Applicant: Review and sign this agreement form authorizing WBE Traffic Control Inc. to perform a background review for your employment consideration.

Consent to Conduct Background Check and Contact Past Employers
As a condition of and in consideration of employment, I give permission to WBE Traffic Control Inc. to check my personal and employment history. I understand that a background check will include, but not be limited to, verification of all information on my employment application, as well as interviews with past employers. Further, I give permission to WBE Traffic Control Inc. to conduct this check and to discuss results in connection with my employment application.
I understand that WBE Traffic Control Inc. may contact any or all past employers listed on my employment application. Further, per my indication on the employment application, I give permission to my current or past employers to discuss my relevant employment history with the company, verbally or in writing.

No Promise of Employment
I understand that neither the completion of this application nor any other part of my consideration for employment gives any obligation for WBE Traffic Control Inc. to hire me.

Falsification Statement
I attest with my signature below that I have given to WBE Traffic Control true and complete information on this application. No requested information has been concealed. If any information I have provided is untrue, or if I have concealed material information, I understand that this will constitute cause for the denial of employment or immediate dismissal.

Equal Employment Statement
WBE Traffic Control Inc. is an equal opportunity employer and does not discriminate in employment because of race, color, religion, sex (including pregnancy, gender identity, and sexual orientation), national origin, age (40 or older), disability, or genetic information.
Acknowledgment of Background Release Agreement of Information
My signature acknowledges that I have carefully reviewed, acknowledge, and agree that WBE Traffic Control Inc. may perform a background review as described above.

Applicant signature: _____

Date: _____

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CARMICHAEL, CA 95608
707-771-5870
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NOTICE TO EMPLOYEE

Labor Code section 2810.5

EMPLOYEE

Employee Name: _____

Start Date: _____

EMPLOYER

Legal Name of Hiring Employer: WBE TRAFFIC CONTROL INC.

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

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

Physical Address of Hiring Employer's Main Office:
10359 Macready Ave. Mather, CA 95655

Hiring Employer's Mailing Address (if different than above):
5150 FAIR OAKS BLVD. STE 101-362 CARMICHAEL CA 95608

Hiring Employer's Telephone Number: 707-771-5870

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

Name: N/A

Physical Address of Main Office: _____

Mailing Address: _____

Telephone Number: _____

WAGE INFORMATION

Rate(s) of Pay: Per agreement Overtime Rate(s) of Pay: Per agreement

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

☐ Other (provide specifics): _____

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

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

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

_____

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

Regular Payday: FRIDAY / WEEKLY

WORKERS' COMPENSATION

Insurance Carrier's Name: STATE COMPENSATION INSURANCE FUND
Address: 5880 OWENS DR. PLEASANTON CA 94588
Telephone Number: (888) 782-8338
Policy No.: 9249432
□ Self-Insured (Labor Code 3700) and Certificate Number for Consent to Self-Insure: _____

PAID SICK LEAVE

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

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

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

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

ACKNOWLEDGEMENT OF RECEIPT

Alice Barnhart
(PRINT NAME of Employer representative)

Alice Barnhart
(SIGNATURE of Employer Representative)

(Date)

(PRINT NAME of Employee)

(SIGNATURE of Employee)

(Date)

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

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

Employment Confidentiality Agreement

I, (print name) _____

hereinafter referred to as EMPLOYEE, in consideration of my employment with WBE Traffic Control Inc. thereinafter referred to as EMPLOYER agree to the following:

1. Employee hereby acknowledges that Employer has placed them in a position of trust and confidence and agrees that during their employment, and at any time thereafter, they will not either directly or indirectly disclose to any person, firm, or corporation or use for their own personal benefit, any matters affecting or relating to the Employers' business including, but not limited to, the names of and confidential information concerning Employer's customers, trade secrets, manner of operations, electronic data processing systems, insurance rates or any other information concerning the business of the Employer, except as required in Employees' duties to Employer.
2. Employee acknowledges the fact that they have access to confidential information concerning other Employees of the Employer and agrees that during the term of their employment, and at any time thereafter, they will not either directly or indirectly disclose to any persons, firm, or corporation, or avail themself of any confidential information concerning other Employees of Employer, except as required in Employees' duties to Employer.
3. Upon termination of employment, Employee will promptly deliver to Employer all manuals, identification cards, letters, notes, notebooks, reports, technology and all other materials of a secret or confidential nature relating to Employers' business and which are in possession of the Employee.

Acknowledgment of Confidentiality Agreement

My signature acknowledges that I have carefully reviewed, acknowledge, and agree with the confidentiality agreement as described above.

Applicant signature: _____Date: _____

Consent and Release Agreement

As an employee of WBE Traffic Control Inc. I give my permission to its legal representatives and assigns, those for whom my employer is acting, and those acting with its permission, or its employees, the permission to take photographs, videos, images, likeness of me and/or any statements from me in its publications, advertising, or other media, including the Internet and use them for any legal purpose

I understand that I will not be paid for the use and have no rights to them. I am participating as a volunteer. I hereby waive any right to inspect or approve the finished photograph or advertising copy or printed matter that may be used in conjunction therewith or to the eventual use that it might be applied.

I release my employer, its officers, employees, and agents, from any and all claims of harm and liability as a result of any distortion, blurring, or alteration, optical illusion, or use in composite form, either intentionally or otherwise which may occur from making, showing, using or distributing these photographs/video.

Acknowledgment of Consent and Release Agreement

I HAVE READ THIS RELEASE AND CONSENT FORM BEFORE PLACING MY SIGNATURE BELOW, AND I UNDERSTAND AND AGREE TO ITS TERMS.

Name: _____

Signature: _____ Date: _____

I DO NOT AGREE TO ITS TERMS.

Name: _____

Signature: _____ Date: _____

5150 FAIR OAKS BLVD STE 101-362

CARMICHAEL, CA 95608

707-771-5870

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Self-Certification of COVID-19 Vaccine Status

WBE Traffic Control continues to strive to maintain a workplace that is free from recognized hazards and to promote the health and well-being of our employees, their families, those who visit our facilities, as well as the public at large. As part of this effort, the Company has implemented certain safety protocols. Consistent with a certain state, CDC, and OSHA guidance, those employees who have been fully vaccinated against COVID-19 will be excused from some of these protocols. For this reason, the Company is requesting that you provide us with your COVID-19 vaccination status.

For purposes of this inquiry, an individual is considered "fully vaccinated" when it has been at least two weeks since receiving the final dose, as recommended by the manufacturer, of a vaccine that has been authorized by the FDA for use in the United States, including vaccinations that have been approved pursuant to an Emergency Use Authorization.

Please note that you are required to provide accurate information about your vaccination status, or you may decline to provide your vaccination status. If you decline to provide information about your vaccination status, we will assume you are unvaccinated for purposes of rules or requirements in the workplace that are different for fully vaccinated or unvaccinated persons.

When responding to this inquiry about whether you have been vaccinated, provide no more information than is contained on a COVID-19 Vaccination Record Card (i.e., if you have been vaccinated, the provider that administered your vaccine; which vaccine you received; and date(s) on which it was administered). Please do not submit any additional medical or family history information in response to the Company's inquiry, including a reason for deciding to be vaccinated or not to be vaccinated.

In lieu of this Self-Certification, employees may present a copy of their completed COVID-19 Vaccination Record Card. All information provided will be maintained in compliance with all applicable laws.

I understand I am required to provide accurate information in response to the questions below and that failure to do so may result in disciplinary action. By signing below, I certify that I have accurately and truthfully answered the questions. I also understand that if I stated that I am fully vaccinated, the Company may request documentation of my vaccination status (e.g., a copy of my vaccine card). I also understand that if I do not follow the required safety protocols consistent with my vaccination status, I am subject to disciplinary action, up to and including termination.

Declaration of COVID-19 Vaccine Status

Date: _____

Name: _____

Signature: _____

☐	Fully Vaccinated: List Manufacture	Dates of Dose(s) 1. _____ 2. _____
☐	Partially Vaccinated: List Manufacture	Dates of Dose(s) 1. _____
☐	Not Yet Vaccinated. COVID-19 Appointment Scheduled.	
☐	Not Yet Vaccinated.	
☐	Decline to Answer	

Authorization for Direct Deposit

This authorizes WBE Traffic Control, Inc. (the "Company") to send credit entries and appropriate debit and adjustment entries, electronically or by any other commercially accepted method, to my (our) account(s) indicated below and to other accounts I (we) identify in the future (the "Account"). This authorizes the financial institution holding the Account to post all such entries.

Account #1

Account #1: Type (circle one): Checking / Saving

Employee Bank Name: _____

Bank Routing # (ABA#) _____Account # _____

Percentage or Dollar Amount to be Deposited to This Account: _____

Account #2 (Remainder to be deposited to this account)

Account #2: Type (circle one): Checking / Saving

Employee Bank Name: _____

Bank Routing # (ABA#) _____Account # _____

Attach a voided check for each bank account here. (Not necessary, if clearly written above)

This authorization will be in effect until the Company receives a written termination notice from myself and has reasonable opportunity to act on it.

Signature: _____ Printed Name: _____

Employee ID#: _____ Date: _____

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CARMICHAEL, CA 95608

707-771-5870

WWW.WBETC.COM

Employment Development Department
State of California

This form can be used to manually compute your withholding allowances, or you can electronically compute them at **www.taxes.ca.gov/de4.pdf.**

EMPLOYEE'S WITHHOLDING ALLOWANCE CERTIFICATE

Type or Print Your Full Name	Your Social Security Number
Home Address (Number and Street or Rural Route)	Filing Status Withholding Allowances ☐ SINGLE or MARRIED (with two or more incomes) ☐ MARRIED (one income) ☐ HEAD OF HOUSEHOLD
City, State, and ZIP Code	

1. Number of allowances for Regular Withholding Allowances, Worksheet A _____
   Number of allowances from the Estimated Deductions, Worksheet B _____
   Total Number of Allowances (A + B) when using the California Withholding Schedules for 2018 _____
   OR
2. Additional amount of state income tax to be withheld each pay period (if employer agrees), Worksheet C _____
   OR
3. 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. (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.

Signature _____ Date _____

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

cut here

Give the top portion of this page to your employer and keep the remainder for your records.

YOUR CALIFORNIA PERSONAL INCOME **TAX MAY BE UNDERWITHHELD** IF YOU DO NOT FILE THIS DE 4 FORM.

IF YOU RELY ON THE FEDERAL FORM W-4 FOR YOUR CALIFORNIA WITHHOLDING ALLOWANCES, YOUR CALIFORNIA STATE PERSONAL INCOME TAX MAY BE UNDERWITHHELD AND YOU MAY OWE MONEY AT THE END OF THE YEAR.

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.

You should complete this form if either:

(1) You claim a different marital status, number of regular allowances, or different additional dollar amount to be withheld for California PIT withholding than you claim for federal income tax withholding or,

(2) You claim additional allowances for estimated deductions.

THIS FORM WILL NOT CHANGE YOUR FEDERAL WITHHOLDING ALLOWANCES.

The federal Form W-4 is applicable for California withholding purposes if you wish to claim the same marital status, number of regular allowances, and/or the same additional dollar amount to be withheld for state and federal purposes. However, federal tax brackets and withholding methods do not reflect state PIT withholding tables. **If you rely on the number of withholding allowances you claim on your Form W-4 withholding allowance certificate for your state income tax withholding, you may be significantly underwithheld.** This is particularly true if your household income is derived from more than one source.

CHECK YOUR WITHHOLDING: After your Form W-4 and/or 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. You may claim exempt from withholding California income tax if you did not owe any federal income tax last year and you do not expect to owe any federal income tax this year. The exemption is good for one year. If you continue to qualify for the exempt filing status, a new Form W-4 designating EXEMPT must be submitted by February 15 each year to continue your exemption. If you are not having federal income tax withheld this year but expect to have a tax liability next year, you are required to give your employer a new Form W-4 by December 1.

EXEMPTION FROM WITHHOLDING (continued): Under the Service Member Civil Relief Act, as amended by the Military Spouses Residency Relief Act, you may be exempt from California income tax on your wages if (i) your spouse is a member of the armed forces present in California in compliance with military orders; (ii) you are present in California solely to be with your spouse; and (iii) you maintain your domicile in another state. If you claim exemption under this act, check the box on Line 3. You may be required to provide proof of exemption upon request.

IF YOU NEED MORE DETAILED INFORMATION, SEE THE INSTRUCTIONS THAT CAME WITH YOUR LAST CALIFORNIA RESIDENT INCOME TAX RETURN OR CALL THE FRANCHISE TAX BOARD (FTB).

IF YOU ARE CALLING FROM WITHIN THE UNITED STATES	1-800-852-5711 (voice) 1-800-822-6268 (TTY)
IF YOU ARE CALLING FROM OUTSIDE THE UNITED STATES (Not Toll Free)	1-916-845-6500

The *California Employer's Guide*, DE 44, provides the income tax withholding tables. This publication may be found on the Employment Development Department (EDD) website at **www.edd.ca.gov/Payroll_Taxes/Forms_and_Publications.htm**. To assist you in calculating your tax liability, please visit the FTB website at **www.ftb.ca.gov/individuals/index.shtml**.

NOTIFICATION: If the IRS instructs your employer to withhold federal income tax based on a certain withholding status, your employer is required to use the same withholding status for state income tax withholding.

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

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

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

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.
		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		
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				

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.

Supplement A,
Preparer and/or Translator Certification for Section 1

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

USCIS
Form I-9
Supplement A
OMB No. 1615-0047
Expires 07/31/2026

Last Name *(Family Name)* from **Section 1.**	First Name *(Given Name)* from **Section 1.**	Middle initial (if any) from **Section 1.**

Instructions: This supplement must be completed by any preparer and/or translator who assists an employee in completing Section 1 of Form I-9. The preparer and/or translator must enter the employee's name in the spaces provided above. Each preparer or translator must complete, sign, and date a separate certification area. Employers must retain completed supplement sheets with the employee's completed Form I-9.

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

Signature of Preparer or Translator			Date *(mm/dd/yyyy)*
Last Name *(Family Name)*	First Name *(Given Name)*		Middle Initial *(if any)*
Address *(Street Number and Name)*	City or Town	State	ZIP Code

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

Signature of Preparer or Translator			Date *(mm/dd/yyyy)*
Last Name *(Family Name)*	First Name *(Given Name)*		Middle Initial *(if any)*
Address *(Street Number and Name)*	City or Town	State	ZIP Code

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

Signature of Preparer or Translator			Date *(mm/dd/yyyy)*
Last Name *(Family Name)*	First Name *(Given Name)*		Middle Initial *(if any)*
Address *(Street Number and Name)*	City or Town	State	ZIP Code

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

Signature of Preparer or Translator			Date *(mm/dd/yyyy)*
Last Name *(Family Name)*	First Name *(Given Name)*		Middle Initial *(if any)*
Address *(Street Number and Name)*	City or Town	State	ZIP Code

Supplement B,

Reverification and Rehire (formerly Section 3)

Department of Homeland Security

U.S. Citizenship and Immigration Services

USCIS
Form I-9
Supplement B
OMB No. 1615-0047
Expires 07/31/2026

Last Name *(Family Name)* from **Section 1.**	First Name *(Given Name)* from **Section 1.**	Middle initial (if any) from **Section 1.**

Instructions: This supplement replaces Section 3 on the previous version of Form I-9. Only use this page if your employee requires reverification, is rehired within three years of the date the original Form I-9 was completed, or provides proof of a legal name change. Enter the employee's name in the fields above. Use a new section for each reverification or rehire. Review the Form I-9 instructions before completing this page. Keep this page as part of the employee's Form I-9 record. Additional guidance can be found in the Handbook for Employers: Guidance for Completing Form I-9 (M-274)

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

Reverification: If the employee requires reverification, your employee can choose to present any acceptable List A or List C documentation to show continued employment authorization. Enter the document information in the spaces below.

Document Title	Document Number (if any)	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 documentation, the documentation I examined appears to be genuine and to relate to the individual who presented it.

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

Additional Information (Initial and date each notation.)

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

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

Reverification: If the employee requires reverification, your employee can choose to present any acceptable List A or List C documentation to show continued employment authorization. Enter the document information in the spaces below.

Document Title	Document Number (if any)	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 documentation, the documentation I examined appears to be genuine and to relate to the individual who presented it.

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

Additional Information (Initial and date each notation.)

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

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

Reverification: If the employee requires reverification, your employee can choose to present any acceptable List A or List C documentation to show continued employment authorization. Enter the document information in the spaces below.

Document Title	Document Number (if any)	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 documentation, the documentation I examined appears to be genuine and to relate to the individual who presented it.

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

Additional Information (Initial and date each notation.)

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

STATE OF CALIFORNIA
DMV
DEPARTMENT OF MOTOR VEHICLES
A Public Service Agency

EMPLOYER PULL NOTICE PROGRAM

AUTHORIZATION FOR RELEASE OF DRIVER RECORD INFORMATION

SECTION 1 — DRIVER INFORMATION

I, _____, California Driver License Number, _____, hereby authorize the California Department of Motor Vehicles (DMV) to disclose or otherwise make available, my driving record, to my employer, _____ .
COMPANY NAME

I understand that my employer may enroll me in the Employer Pull Notice (EPN) program to receive a driver record report at least once every twelve (12) months or when any subsequent conviction, failure to appear, accident, driver's license suspension, revocation, or any other action is taken against my driving privilege during my employment.

I am not driving in a capacity that requires mandatory enrollment in the EPN program pursuant to *California Vehicle Code* (CVC) §1808.1(k). I understand that enrollment in the EPN program is in an effort to promote driver safety, and that my driver license report will be released to my employer to determine my eligibility as a licensed driver for my employment.

EXECUTED AT: CITY _____ COUNTY _____ STATE _____

DATE	SIGNATURE OF EMPLOYEE
	X

SECTION 2 — AUTHORIZED REPRESENTATIVE CERTIFICATION

I, _____ , of _____
AUTHORIZED REPRESENTATIVE COMPANY NAME

do hereby certify under penalty of perjury under the laws in the State of California, that I am an authorized representative of this company, that the information entered on this document is true and correct, to the best of my knowledge and that I am requesting driver record information on the above individual to verify the information as provided by said individual. This record is to be used by this employer in the normal course of business and as a legitimate business need to verify information relating to a driving position not mandated pursuant to CVC §1808.1. The information received will not be used for any unlawful purpose. I understand that if I have provided false information, I may be subject to prosecution for perjury (*Penal Code* §118) and false representation (CVC §1808.45). These are punishable by a fine not exceeding five thousand dollars ($5,000) or by imprisonment in the county jail not exceeding one year, or both fine and imprisonment. I understand and acknowledge that any failure to maintain confidentiality is both civilly and criminally punishable pursuant to CVC §§1808.45 and 1808.46.

EXECUTED AT: CITY _____ COUNTY _____ STATE _____

DATE	SIGNATURE AND TITLE OF AUTHORIZED REPRESENTATIVE
	X *Alice Barnhart*

To obtain a driver record on a prospective employee you may submit an INF 1119 form. To add this driver to the EPN Program you must submit the applicable forms: INF 1100, INF 1102, INF 1103, INF 1103A form. You may obtain forms at our website at **dmv.ca.gov/otherservices**, or by calling 916-657-6346.

PLEASE RETAIN AT THE EMPLOYER'S PRINCIPAL PLACE OF BUSINESS *AND* MAKE AVAILABLE UPON REQUEST TO DMV STAFF.

DO ***NOT*** RETURN THIS FORM TO DMV.

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

2024

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, and when to use the estimator at *www.irs.gov/W4App*.

Step 2: Multiple Jobs or Spouse Works

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

Do **only one** of the following.

(a) Use the estimator at *www.irs.gov/W4App* for most accurate withholding for this step (and Steps 3–4). If you or your spouse have self-employment income, use this option; **or**

(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 . . . . . ☐

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)

General Instructions

Section references are to the Internal Revenue Code.

Future Developments

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

Purpose of Form

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

Exemption from withholding. You may claim exemption from withholding for 2024 if you meet both of the following conditions: you had no federal income tax liability in 2023 **and** you expect to have no federal income tax liability in 2024. You had no federal income tax liability in 2023 if (1) your total tax on line 24 on your 2023 Form 1040 or 1040-SR is zero (or less than the sum of lines 27, 28, and 29), or (2) you were not required to file a return because your income was below the filing threshold for your correct filing status. If you claim exemption, you will have no income tax withheld from your paycheck and may owe taxes and penalties when you file your 2024 tax return. To claim exemption from withholding, certify that you meet both of the conditions above by writing "Exempt" on Form W-4 in the space below Step 4(c). Then, complete Steps 1(a), 1(b), and 5. Do not complete any other steps. You will need to submit a new Form W-4 by February 15, 2025.

Your privacy. Steps 2(c) and 4(a) ask for information regarding income you received from sources other than the job associated with this Form W-4. If you have concerns with providing the information asked for in Step 2(c), you may choose Step 2(b) as an alternative; if you have concerns with providing the information asked for in Step 4(a), you may enter an additional amount you want withheld per pay period in Step 4(c) as an alternative.

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

1. Expect to work only part of the year;

2. Receive dividends, capital gains, social security, bonuses, or business income, or are subject to the Additional Medicare Tax or Net Investment Income Tax; or

3. Prefer the most accurate withholding for multiple job situations.

Self-employment. Generally, you will owe both income and self-employment taxes on any self-employment income you receive separate from the wages you receive as an employee. If you want to pay these taxes through withholding from your wages, use the estimator at *www.irs.gov/W4App* to figure the amount to have withheld.

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

Specific Instructions

Step 1(c). Check your anticipated filing status. This will determine the standard deduction and tax rates used to compute your withholding.

Step 2. Use this step if you (1) have more than one job at the same time, or (2) are married filing jointly and you and your spouse both work.

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

Instead, if you (and your spouse) have a total of only two jobs, you may check the box in option **(c)**. The box must also be checked on the Form W-4 for the other job. If the box is checked, the standard deduction and tax brackets will be cut in half for each job to calculate withholding. This option is accurate for jobs with similar pay; otherwise, more tax than necessary may be withheld, and this extra amount will be larger the greater the difference in pay is between the two jobs.

Multiple jobs. *Complete Steps 3 through 4(b) on only one Form W-4. Withholding will be most accurate if you do this on the Form W-4 for the highest paying job.*

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

Step 4 (optional).

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

Step 4(b). Enter in this step the amount from the Deductions Worksheet, line 5, if you expect to claim deductions other than the basic standard deduction on your 2024 tax return and want to reduce your withholding to account for these deductions. This includes both itemized deductions and other deductions such as for student loan interest and IRAs.

Step 4(c). Enter in this step any additional tax you want withheld from your pay **each pay period**, including any amounts from the Multiple Jobs Worksheet, line 4. Entering an amount here will reduce your paycheck and will either increase your refund or reduce any amount of tax that you owe.

Step 2(b)—Multiple Jobs Worksheet *(Keep for your records.)*

If you choose the option in Step 2(b) on Form W-4, complete this worksheet (which calculates the total extra tax for all jobs) on **only ONE** Form W-4. Withholding will be most accurate if you complete the worksheet and enter the result on the Form W-4 for the highest paying job. To be accurate, submit a new Form W-4 for all other jobs if you have not updated your withholding since 2019.

Note: If more than one job has annual wages of more than $120,000 or there are more than three jobs, see Pub. 505 for additional tables; or, you can use the online withholding estimator at *www.irs.gov/W4App*.

1 **Two jobs.** If you have two jobs or you're married filing jointly and you and your spouse each have one job, find the amount from the appropriate table on page 4. Using the "Higher Paying Job" row and the "Lower Paying Job" column, find the value at the intersection of the two household salaries and enter that value on line 1. Then, **skip** to line 3 . . . . . **1** $

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

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

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

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

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

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

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

1 Enter an estimate of your 2024 itemized deductions (from Schedule A (Form 1040)). Such deductions may include qualifying home mortgage interest, charitable contributions, state and local taxes (up to $10,000), and medical expenses in excess of 7.5% of your income . . . . . **1** $

2 Enter:
- $29,200 if you're married filing jointly or a qualifying surviving spouse
- $21,900 if you're head of household
- $14,600 if you're single or married filing separately

. . . . . **2** $

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

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

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

Privacy Act and Paperwork Reduction Act Notice. We ask for the information on this form to carry out the Internal Revenue laws of the United States. Internal Revenue Code sections 3402(f)(2) and 6109 and their regulations require you to provide this information; your employer uses it to determine your federal income tax withholding. Failure to provide a properly completed form will result in your being treated as a single person with no other entries on the form; providing fraudulent information may subject you to penalties. Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation; to cities, states, the District of Columbia, and U.S. commonwealths and territories for use in administering their tax laws; and to the Department of Health and Human Services for use in the National Directory of New Hires. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

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

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

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

Married Filing Jointly or Qualifying Surviving Spouse

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	$0 - 9,999	$10,000 - 19,999	$20,000 - 29,999	$30,000 - 39,999	$40,000 - 49,999	$50,000 - 59,999	$60,000 - 69,999	$70,000 - 79,999	$80,000 - 89,999	$90,000 - 99,999	$100,000 - 109,999	$110,000 - 120,000
$0 - 9,999	$0	$0	$780	$850	$940	$1,020	$1,020	$1,020	$1,020	$1,020	$1,020	$1,370
$10,000 - 19,999	0	780	1,780	1,940	2,140	2,220	2,220	2,220	2,220	2,220	2,570	3,570
$20,000 - 29,999	780	1,780	2,870	3,140	3,340	3,420	3,420	3,420	3,420	3,770	4,770	5,770
$30,000 - 39,999	850	1,940	3,140	3,410	3,610	3,690	3,690	3,690	4,040	5,040	6,040	7,040
$40,000 - 49,999	940	2,140	3,340	3,610	3,810	3,890	3,890	4,240	5,240	6,240	7,240	8,240
$50,000 - 59,999	1,020	2,220	3,420	3,690	3,890	3,970	4,320	5,320	6,320	7,320	8,320	9,320
$60,000 - 69,999	1,020	2,220	3,420	3,690	3,890	4,320	5,320	6,320	7,320	8,320	9,320	10,320
$70,000 - 79,999	1,020	2,220	3,420	3,690	4,240	5,320	6,320	7,320	8,320	9,320	10,320	11,320
$80,000 - 99,999	1,020	2,220	3,620	4,890	6,090	7,170	8,170	9,170	10,170	11,170	12,170	13,170
$100,000 - 149,999	1,870	4,070	6,270	7,540	8,740	9,820	10,820	11,820	12,830	14,030	15,230	16,430
$150,000 - 239,999	1,960	4,360	6,760	8,230	9,630	10,910	12,110	13,310	14,510	15,710	16,910	18,110
$240,000 - 259,999	2,040	4,440	6,840	8,310	9,710	10,990	12,190	13,390	14,590	15,790	16,990	18,190
$260,000 - 279,999	2,040	4,440	6,840	8,310	9,710	10,990	12,190	13,390	14,590	15,790	16,990	18,190
$280,000 - 299,999	2,040	4,440	6,840	8,310	9,710	10,990	12,190	13,390	14,590	15,790	16,990	18,380
$300,000 - 319,999	2,040	4,440	6,840	8,310	9,710	10,990	12,190	13,390	14,590	15,980	17,980	19,980
$320,000 - 364,999	2,040	4,440	6,840	8,310	9,710	11,280	13,280	15,280	17,280	19,280	21,280	23,280
$365,000 - 524,999	2,720	6,010	9,510	12,080	14,580	16,950	19,250	21,550	23,850	26,150	28,450	30,750
$525,000 and over	3,140	6,840	10,540	13,310	16,010	18,590	21,090	23,590	26,090	28,590	31,090	33,590

Single or Married Filing Separately

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	$0 - 9,999	$10,000 - 19,999	$20,000 - 29,999	$30,000 - 39,999	$40,000 - 49,999	$50,000 - 59,999	$60,000 - 69,999	$70,000 - 79,999	$80,000 - 89,999	$90,000 - 99,999	$100,000 - 109,999	$110,000 - 120,000
$0 - 9,999	$240	$870	$1,020	$1,020	$1,020	$1,540	$1,870	$1,870	$1,870	$1,870	$1,910	$2,040
$10,000 - 19,999	870	1,680	1,830	1,830	2,350	3,350	3,680	3,680	3,680	3,720	3,920	4,050
$20,000 - 29,999	1,020	1,830	1,980	2,510	3,510	4,510	4,830	4,830	4,870	5,070	5,270	5,400
$30,000 - 39,999	1,020	1,830	2,510	3,510	4,510	5,510	5,830	5,870	6,070	6,270	6,470	6,600
$40,000 - 59,999	1,390	3,200	4,360	5,360	6,360	7,370	7,890	8,090	8,290	8,490	8,690	8,820
$60,000 - 79,999	1,870	3,680	4,830	5,840	7,040	8,240	8,770	8,970	9,170	9,370	9,570	9,700
$80,000 - 99,999	1,870	3,690	5,040	6,240	7,440	8,640	9,170	9,370	9,570	9,770	9,970	10,810
$100,000 - 124,999	2,040	4,050	5,400	6,600	7,800	9,000	9,530	9,730	10,180	11,180	12,180	13,120
$125,000 - 149,999	2,040	4,050	5,400	6,600	7,800	9,000	10,180	11,180	12,180	13,180	14,180	15,310
$150,000 - 174,999	2,040	4,050	5,400	6,860	8,860	10,860	12,180	13,180	14,230	15,530	16,830	18,060
$175,000 - 199,999	2,040	4,710	6,860	8,860	10,860	12,860	14,380	15,680	16,980	18,280	19,580	20,810
$200,000 - 249,999	2,720	5,610	8,060	10,360	12,660	14,960	16,590	17,890	19,190	20,490	21,790	23,020
$250,000 - 399,999	2,970	6,080	8,540	10,840	13,140	15,440	17,060	18,360	19,660	20,960	22,260	23,500
$400,000 - 449,999	2,970	6,080	8,540	10,840	13,140	15,440	17,060	18,360	19,660	20,960	22,260	23,500
$450,000 and over	3,140	6,450	9,110	11,610	14,110	16,610	18,430	19,930	21,430	22,930	24,430	25,870

Head of Household

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	$0 - 9,999	$10,000 - 19,999	$20,000 - 29,999	$30,000 - 39,999	$40,000 - 49,999	$50,000 - 59,999	$60,000 - 69,999	$70,000 - 79,999	$80,000 - 89,999	$90,000 - 99,999	$100,000 - 109,999	$110,000 - 120,000
$0 - 9,999	$0	$510	$850	$1,020	$1,020	$1,020	$1,020	$1,220	$1,870	$1,870	$1,870	$1,960
$10,000 - 19,999	510	1,510	2,020	2,220	2,220	2,220	2,420	3,420	4,070	4,070	4,160	4,360
$20,000 - 29,999	850	2,020	2,560	2,760	2,760	2,960	3,960	4,960	5,610	5,700	5,900	6,100
$30,000 - 39,999	1,020	2,220	2,760	2,960	3,160	4,160	5,160	6,160	6,900	7,100	7,300	7,500
$40,000 - 59,999	1,020	2,220	2,810	4,010	5,010	6,010	7,070	8,270	9,120	9,320	9,520	9,720
$60,000 - 79,999	1,070	3,270	4,810	6,010	7,070	8,270	9,470	10,670	11,520	11,720	11,920	12,120
$80,000 - 99,999	1,870	4,070	5,670	7,070	8,270	9,470	10,670	11,870	12,720	12,920	13,120	13,450
$100,000 - 124,999	2,020	4,420	6,160	7,560	8,760	9,960	11,160	12,360	13,210	13,880	14,880	15,880
$125,000 - 149,999	2,040	4,440	6,180	7,580	8,780	9,980	11,250	13,250	14,900	15,900	16,900	17,900
$150,000 - 174,999	2,040	4,440	6,180	7,580	9,250	11,250	13,250	15,250	16,900	18,030	19,330	20,630
$175,000 - 199,999	2,040	4,510	7,050	9,250	11,250	13,250	15,250	17,530	19,480	20,780	22,080	23,380
$200,000 - 249,999	2,720	5,920	8,620	11,120	13,420	15,720	18,020	20,320	22,270	23,570	24,870	26,170
$250,000 - 449,999	2,970	6,470	9,310	11,810	14,110	16,410	18,710	21,010	22,960	24,260	25,560	26,860
$450,000 and over	3,140	6,840	9,880	12,580	15,080	17,580	20,080	22,580	24,730	26,230	27,730	29,230

About California Paid Family Leave

For many working Californians, finding time to be with a loved one when they need it most can be difficult. California's Paid Family Leave program was created for those moments that matter. Benefits are available to care for a seriously ill family member, to bond with a new child, or to participate in a qualifying military event.

Fast Facts About California Paid Family Leave

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

CALIFORNIA
PAID FAMILY LEAVE
moments matter.

Paid Family Leave:
Giving Californians the benefits they need to be there for the moments that matter.

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

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

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

EDD Employment Development Department
State of California

For more information, visit:
CaliforniaPaidFamilyLeave.com

CALIFORNIA PAID FAMILY LEAVE

Helping Californians be present for the moments that matter.

What Are My Benefits During Pregnancy?

Your disability period begins the first day you are unable to do your regular work. DI benefits are based on the period of time your licensed health professional certifies you are unable to do your regular work. You can file a DI claim for your pregnancy-related disability, and recovery from delivery.

Without medical complications, you can receive benefits up to four weeks before your expected delivery date and up to six weeks after your delivery. For cesarean section, you can receive benefits up to eight weeks after delivery.

After your DI pregnancy claim ends, you may be eligible to receive up to eight weeks of Paid Family Leave (PFL) to bond with your new baby. A PFL bonding claim form is automatically sent with the final DI benefit payment.

What If I Require Care During My Disability?

If you require care during your disability, your child, parent, parent-in-law, grandparent, grandchild, sibling, spouse, or registered domestic partner may be eligible to receive up to eight weeks of PFL benefits to take time off work to care for you. For more information visit California PFL (edd.ca.gov/PaidFamilyLeave).

What Is Disability?

Disability is an illness or injury, either physical or mental, which prevents you from doing your regular work. Disability includes elective surgery, pregnancy, childbirth, or related medical conditions.

What Is Disability Insurance?

Disability Insurance (DI) is a part of the State Disability Insurance (SDI) program. DI helps replace your income when you can't work as a result of a non-work-related disability. The program is funded through your SDI tax withholding. You are most likely eligible if you've paid into the SDI program (noted as "CASDI" on paystubs).

Elective Coverage is a plan where employers, the self-employed, and general partners may choose to be covered under SDI. Benefits and eligibility are determined differently between these plans. Find the annual cost of participating at your local Tax Office (edd.ca.gov/office_locator) or by visiting Disability Insurance Elective Coverage (edd.ca.gov/Payroll_Taxes/Disability_Insurance_Elective_Coverage.htm).

Citizenship and immigration status do not affect eligibility for SDI benefits.

CALIFORNIA
PAID FAMILY LEAVE
moments matter.

STATE OF CALIFORNIA

LABOR AND WORKFORCE DEVELOPMENT AGENCY

EMPLOYMENT DEVELOPMENT DEPARTMENT

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

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

Disability Insurance Provisions

Employment Development Department
State of California

How Do I Apply for Disability Insurance Benefits?

1. Use SDI Online (edd.ca.gov/SDI_Online) to file for benefits.

   OR

   You can request a paper claim form by:

   - Visiting Forms and Publications (forms.edd.ca.gov/forms).
   - Calling 1-800-480-3287.

California state government employees covered by SDI should call 1-866-352-7675.

2. After you complete Part A – Claimant's Statement, have your licensed health professional complete Part B - Physician/Practitioner's Certificate online or by using a paper claim form. If you are filing online, SDI Online will provide you a receipt number once Part A is submitted. Your licensed health professional will need your receipt number to complete Part B.

   A claim cannot begin more than seven days before you were examined by or under the care of a licensed health professional.

3. File online or submit your paper claim form within 49 days from the date your disability begins. If your claim is late, you may lose benefits. Visit Appeals (edd.ca.gov/Disability/Appeals.htm) for more information.

What Happens Next?

- A properly completed claim takes two weeks to be processed.
- We will mail you a *Notice of Computation* (DE 429D) confirming we received your claim and providing your estimated benefit amount.
- You will know we approved your claim once you receive an *Electronic Benefit Payment (EBP) Notification* (DE 2500E).
- If more information is needed or if the claim has been denied, we will contact you.

How Are My Benefits Sent to Me?

You have two payment options:

1. EDD Debit Card℠ through Bank of America. (You do not have to accept the EDD Debit Card.)
2. A Check. (Allow 7 to 10 days for delivery of checks in the mail.)

- Most completed claims are processed within 14 days.
- The first seven days of your DI claim are a non-payable waiting period. If a claim is filed for the same or related condition within 60 days of the first claim, it will be added on as a continuation of the initial claim. There is no additional waiting period.
- Benefits are paid once all information is received and you are approved. Benefit periods are two weeks at a time. If you are eligible for additional benefits, you will be sent the needed forms to complete and return. Allow 10 days for processing. If your benefits end midweek, that week will be paid at the daily rate. This rate is one-seventh of your weekly benefit amount.

How Are My Benefits Calculated?

They are based on your paychecks during a specific 12-month period (called a base period) 5 to 18 months before the start of your claim. To qualify, you must have earned at least $300 in your base period.

California's DI provides approximately 60 to 70 percent of your weekly salary. Visit the Disability Insurance and Paid Family Leave Calculator (edd.ca.gov/PFL_Calculator) to get an estimate.

What Affects My Ongoing Benefits?

You cannot be paid more than your normal weekly salary while receiving benefits. DI benefits are not affected by vacation pay you may receive.

Is There a Maximum Amount to My Benefits?

The maximum amount is 52 times the weekly rate of your benefits, but not more than your total base period wages earned when you were employed.

Exception: For employers and self-employed individuals who elect SDI coverage, the maximum benefit amount is 39 times the weekly rate.

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

What Are My Rights If My Benefits Are Denied?

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

Contact DI

- English 1-800-480-3287.
- Spanish 1-866-658-8846.
- By US mail addressed to PO Box 13140, Sacramento, CA 95813-3140. If you do not have a current claim, you may write to any DI office. Note: Do not mail claim forms to this PO Box.
- By TTY (for TTY users only) at 1-800-563-2441.
- In person by visiting any of the DI Offices (edd.ca.gov/office_locator).

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

Do I Qualify For California Paid Family Leave?

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

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

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

How Are Benefit Amounts Calculated?

California Paid Family Leave provides approximately 60 to 70 percent of your weekly salary.

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

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

Does Paid Family Leave Provide Job Protection?

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

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

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

How Do I Apply For Benefits?

Apply for Paid Family Leave benefits by visiting **SDI Online (edd.ca.gov/SDI_Online)**.

You may also apply using a paper form. Visit **EDD Forms and Publications (edd.ca.gov/Forms)** to request a *Claim for Paid Family Leave (PFL) Benefits* (DE 2501F) form.

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

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

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

For military assist claims, you must provide supporting military documentation (e.g., proof of covered active duty or call to covered active duty and documentation of the qualifying event).

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

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

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

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

Civil Rights Department
STATE OF CALIFORNIA

SEXUAL HARASSMENT

THE FACTS

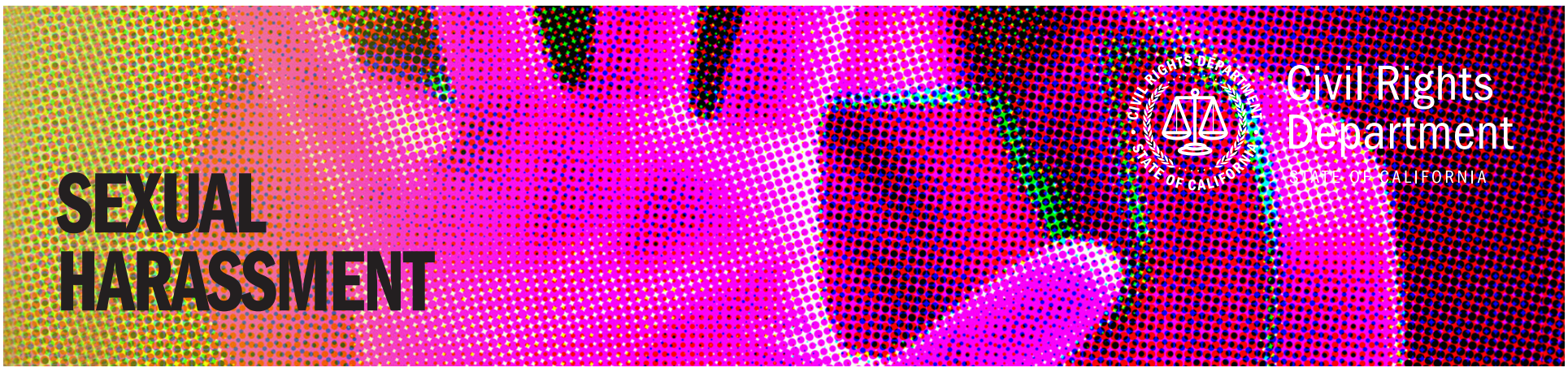
Sexual harassment is a form of discrimination based on sex/gender (including pregnancy, childbirth, or related medical conditions), gender identity, gender expression, or sexual orientation. Individuals of any gender can be the target of sexual harassment. Unlawful sexual harassment does not have to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

THERE ARE TWO TYPES OF SEXUAL HARASSMENT

1. *"Quid pro quo"* (Latin for "this for that") sexual harassment is when someone conditions a job, promotion, or other work benefit on your submission to sexual advances or other conduct based on sex.
2. *"Hostile work environment"* sexual harassment occurs when unwelcome comments or conduct based on sex unreasonably interferes with your work performance or creates an intimidating, hostile, or offensive work environment. You may experience sexual harassment even if the offensive conduct was not aimed directly at you. The harassment must be severe or pervasive to be unlawful. A single act of harassment may be sufficiently severe to be unlawful.

BEHAVIORS THAT MAY BE SEXUAL HARASSMENT

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



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

Employees or job applicants who believe that they have been sexually harassed or retaliated against may file a complaint of discrimination with CRD within three years of the last act of harassment or retaliation. CRD serves as a neutral fact-finder and attempts to help the parties voluntarily resolve disputes.

If CRD finds sufficient evidence to establish that discrimination occurred and settlement efforts fail, the Department may file a civil complaint in state or federal court to address the causes of the discrimination and on behalf of the complaining party. CRD may seek court orders changing the employer's policies and practices, punitive damages, and attorney's fees and costs if it prevails in litigation. Employees can also pursue the matter through a private lawsuit in civil court after a complaint has been filed with CRD and a Right-to-Sue Notice has been issued.

EMPLOYER RESPONSIBILITY & LIABILITY

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

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

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

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

1. Distribute copies of this document or an alternative writing that complies with Government Code 12950. This document may be duplicated in any quantity.

2. Post a copy of the CRD employment poster "California Law Prohibits Workplace Discrimination and Harassment."

3. Develop a harassment, discrimination, and retaliation prevention policy in accordance with 2 CCR 11023.

The policy must:

- Be in writing.
- List all protected groups under the FEHA.
- Indicate that the law prohibits coworkers and third parties, as well as supervisors and managers with whom the employee comes into contact, from engaging in prohibited harassment.
- Create a complaint process that ensures confidentiality to the extent possible; a timely response; an impartial and timely investigation by qualified personnel; documentation and tracking for reasonable progress; appropriate options for remedial actions and resolutions; and timely closures.
- Provide a complaint mechanism that does not require an employee to complain directly to their immediate supervisor.
- That complaint mechanism must include, but is not limited to including: provisions for direct communication, either orally or in writing, with a designated company representative; and / or a complaint hotline; and/ or access to an ombudsperson; and/ or identification of CRD and the United States Equal Employment Opportunity Commission as additional avenues for employees to lodge complaints.
- Instruct supervisors to report any complaints of misconduct to a designated company representative, such as a human resources manager, so that the company can try to resolve the claim internally. Employers with 50 or more employees are required to include this as a topic in mandated sexual harassment prevention training (see 2 CCR 11024).
- Indicate that when the employer receives allegations of misconduct, it will conduct a fair, timely, and thorough investigation that provides all parties appropriate due process and reaches reasonable conclusions based on the evidence collected.
- Make clear that employees shall not be retaliated against as a result of making a complaint or participating in an investigation.

4. Distribute its harassment, discrimination, and retaliation prevention policy by doing one or more of the following:

- Printing the policy and providing a copy to employees with an acknowledgment form for employees to sign and return.
- Sending the policy via email with an acknowledgment return form.
- Posting the current version of the policy on a company intranet with a tracking system to ensure all employees have read and acknowledged receipt of the policy.
- Discussing policies upon hire and/or during a new hire orientation.
- Using any other method that ensures employees received and understand the policy.

5. If the employer's workforce at any facility or establishment contains ten percent or more of persons who speak a language other than English as their spoken language, that employer shall translate the harassment, discrimination, and retaliation policy into every language spoken by at least ten percent of the workforce.

6. In addition, employers who do business in California and employ 5 or more part-time or full-time employees must provide at least one hour of training regarding the prevention of sexual harassment, including harassment based on gender identity, gender expression, and sexual orientation, to each non-supervisory employee; and two hours of such training to each supervisory employee. All employees must be trained by January 1, 2023. New supervisory employees must be trained within six months of assuming their supervisory position, and new non-supervisory employees must be trained within six months of hire. Employees must be retrained once every two years. Please see Gov. Code 12950.1 and 2 CCR 11024 for further information.

CIVIL REMEDIES

1. Damages for emotional distress from each employer or person in violation of the law

2. Hiring or reinstatement

3. Back pay or promotion

4. Changes in the policies or practices of the employer

To schedule an appointment, contact the Communication Center below.

If you have a disability that requires a reasonable accommodation, the CRD can assist you by scribing your intake by phone or, for individuals who are Deaf or Hard of Hearing or have speech disabilities, through the California Relay Service (711), or you can contact us below.

TO FILE A COMPLAINT

Civil Rights Department
calcivilrights.ca.gov/complaintprocess
Toll Free: 800.884.1684 / TTY: 800.700.2320
California Relay Service (711)

Have a disability that requires a reasonable accommodation? CRD can assist you with your complaint.

For translations of this guidance, visit: www.calcivilrights.ca.gov/posters/required

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

RIGHTS OF VICTIMS OF DOMESTIC VIOLENCE, SEXUAL ASSAULT, STALKING, CRIMES THAT CAUSE PHYSICAL INJURY OR MENTAL INJURY, AND CRIMES INVOLVING A THREAT OF PHYSICAL INJURY; AND OF PERSONS WHOSE IMMEDIATE FAMILY MEMBER IS DECEASED AS A DIRECT RESULT OF A CRIME

Your Right to Take Time Off:

- You have the right to take time off from work to obtain relief from a court, including obtaining a restraining order, to protect you and your children's health, safety or welfare.
- If your company has 25 or more workers, you can take time off from work to get medical attention for injuries caused by crime or abuse, receive services from a domestic violence shelter, program, rape crisis center, or victim services organization or agency as a result of the crime or abuse, receive psychological counseling or mental health services related to an experience of crime or abuse, or participate in safety planning and take other actions to increase safety from future crime or abuse.
- You may use accrued paid sick leave or vacation, personal leave, or compensatory time off that is otherwise available for your leave unless you are covered by a union agreement that says something different. Even if you don't have paid leave, you still have the right to time off.
- In general, you don't have to give your employer proof to use leave for these reasons.
- If you can, you should tell your employer before you take time off. Even if you cannot tell your employer beforehand, your employer cannot discipline you if you give proof explaining the reason for your absence within a reasonable time. Proof can be a police report, a court order, a document from a licensed medical professional, a victim advocate, a licensed health care provider, or counselor showing that you were undergoing treatment for domestic violence related trauma, or a written statement signed by you, or an individual acting on your behalf, certifying that the absence is for an authorized purpose.

Your Right to Reasonable Accommodation:

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

Your Right to Be Free from Retaliation and Discrimination:

Your employer cannot treat you differently or fire you because:

- You are a victim of domestic violence, sexual assault, stalking, a crime that caused physical injury or mental injury, or a crime involving threat of physical injury; or are someone whose immediate family member is deceased as a direct result of a crime.
- You asked for leave time to get help.
- You asked your employer for help or changes in the workplace to make sure you are safe at work.

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

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

Labor Commissioner's Office Victims of Domestic Violence, Sexual Assault and Stalking Notice 3/2021

DI Office Locations and Mailing Addresses

Chico ..... 645 Salem Street
(PO Box 8190, Chico, CA 95927-8190)

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

Fresno ..... 2555 S. Elm Avenue
(PO Box 32, Fresno, CA 93707-0032)

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

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

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

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

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

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

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

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

Santa Ana ..... 2 MacArthur Place, Suite 400
(PO Box 1466, Santa Ana, CA 92702-1466)

Santa Barbara ..... 128 East Ortega Street
(PO Box 1529, Santa Barbara, CA 93102-1529)

Santa Rosa ..... 606 Healdsburg Avenue
(PO Box 700, Santa Rosa, CA 95402-0700)

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

California State Government Employees
(PO Box 2168, Stockton, CA 95201-2168)

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

STATE OF CALIFORNIA

LABOR AND WORKFORCE DEVELOPMENT AGENCY

EMPLOYMENT DEVELOPMENT DEPARTMENT

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

EDD Employment Development Department
State of California

DISABILITY INSURANCE PROVISIONS

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

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

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

DI Plans

- State Plan. The DI state plan is covered in this brochure.
- Voluntary Plan (VP). A private plan, which may be substituted for the State Plan. Voluntary Plans are established if the employer and majority of employees agree to do so. VP information and filing a claim is done through your employer. If you are covered by a VP, the provisions of this brochure may not apply to you. Obtain information about your coverage and file a VP claim through your employer.
- Elective Coverage (EC). Employers and self-employed persons, including general partners, may elect coverage under SDI. The method of computing benefits for EC participants is not the same as for mandatory rate payers. The cost of participating, which is set annually, can be obtained from your local EDD Employment Tax Customer Service Office.

  EC claims are filed in the same manner as State Plan claims. However, there are differences in eligibility requirements from those listed in this pamphlet.

For additional information or to apply for coverage, contact the EDD DI customer service at 1-800-480-3287, the EDD employment tax customer service at 1-888-745-3886, or visit State Disability Insurance (edd.ca.gov/disability).

How to Claim State Plan Benefits

1. Use **SDI Online** to securely file for benefits or request a paper claim form online.
   - Online: State Disability Insurance (edd.ca.gov/disability).
   - By phone: 1-800-480-3287.
   - By mail: EDD, Disability Insurance, PO Box 989777, West Sacramento, CA 95798-9777.
   - California state government employees covered by SDI should call 1-866-352-7675.
2. If filing through SDI Online, complete all required fields. SDI Online will provide a receipt number once the claim is submitted.

   If using a paper *Claim for Disability Insurance (DI) Benefits* (DE 2501) form, complete and sign Part A-Claimant's Statement. Print clearly, and verify your answers are complete and correct as errors delay payment.
3. Have your physician/practitioner complete the Part B - Physician/Practitioner's Certificate online or use the paper claim form. If filing online, your physician/practitioner will need your receipt number to complete the Part B - Physician/Practitioner's Certificate.

   Usually a claim cannot begin more than seven days before you were examined by or under the care of a physician/practitioner. Certification may be made by a:
   - Licensed medical or osteopathic physician and surgeon.
   - Nurse practitioner.
   - Physician assistant.
   - Chiropractor.
   - Dentist.
   - Podiatrist.
   - Optometrist.
   - Designated psychologist.
   - Authorized medical officer of a United States governmental facility.

   Certification may also be made by a licensed nurse-midwife or licensed midwife for disabilities related to normal pregnancy or childbirth.
4. File online or submit your paper claim form within 49 days from the date your disability begins. If your claim is late, you may lose benefits unless your explanation of the delay is accepted as reasonable.

How Benefits Are Paid

- If you are eligible to receive benefits, you have two payment options: by **EDD Debit Card**[SM] through Bank of America, or by a **check**. You do not have to accept the EDD Debit Card. Please allow 7 to 10 days for delivery of checks in the mail.
- Most properly completed claims are processed within 14 days.
- The first seven days of your DI claim are a non-payable waiting period. If a claim is filed for the same or related cause or condition within 60 days of the initial claim, it will be processed as a continuation of the initial claim for which a waiting period was already served. There will not be a new waiting period in such cases.

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

How Your Benefit Rate is Determined

Benefit amounts are based on wages paid during a specific 12-month **base period**, determined by the date your claim begins. Consider when to start your claim since this may affect your weekly benefit rate, your maximum benefit amount, and the period of your benefit eligibility.

Only **base period** wages subject to the SDI contributions can be used in computing your benefits. To qualify, you must have earned at least $300 during your base period. The month your claim begins determines which four consecutive quarters are used.

If your claim begins in:

- **January, February, or March, your base period is the 12 months ending last September 30.** (Example: A claim beginning February 14, 2021, uses a base period of October 1, 2019, through September 30, 2020.)
- **April, May, or June, your base period is the 12 months ending last December 31.** (Example: A claim beginning June 20, 2021, uses a base period of January 1, 2020, through December 31, 2020.)
- **July, August, or September, your base period is the 12 months ending last March 31.** (Example: A claim beginning September 27, 2021, uses a base period of April 1, 2020, through March 31, 2021.)
- **October, November, or December, your base period is the 12 months ending last June 30.** (Example: A claim beginning November 2, 2021, uses a base period of July 1, 2020, through June 30, 2021.)

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

You may be entitled to substitute wages paid in prior quarters to either validate your claim or increase your benefit amount, if during your base period you:

- Were in the military service.
- Received workers' compensation benefits.
- Did not work because of a labor dispute.

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

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

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

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

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

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

You May Not Be Eligible for Benefits

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

The California Unemployment Insurance Code provides for penalties consisting of fines, imprisonment, and loss of benefit rights for fraud against the SDI program.

Your Rights

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

Your Obligations

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

Contact DI

- By phone at:
  - English 1-800-480-3287
  - Spanish 1-866-658-8846
- By **U.S. mail** addressed to PO Box 13140, Sacramento, CA 95813-3140. If you do not have a current claim, you may write to any DI office. **Note:** Do not mail claim forms to this PO Box.
- By **TTY** (for TTY users only) at 1-800-563-2441.
- **In person** by visiting any of the DI offices listed under "DI Office Locations."

Other Programs

If you are injured on the job or become ill as a result of your occupation, notify your employer.

If you are able and available to work but unemployed, contact the UI program by visiting Unemployment Insurance (edd.ca.gov/unemployment) or by phone at 1-800-300-5616 (TTY 1-800-815-9387).

If you need help in finding work, job training, retraining, or other services in order to return to work, visit your local America's Job Center of California[SM] listed at Service Locator (careeronestop.org/LocalHelp/service-locator.aspx) or in the white pages of your phone directory.

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

If you need time off work for a family leave, PFL provides benefits to:

- Care for a seriously ill family member (child, parent, parent-in-law, grandparent, grandchild, sibling, spouse, or registered domestic partner).
- Bond with a new child entering the family (through birth, adoption, or foster care placement).
- Participate in a qualifying event resulting from a family member's (spouse, registered domestic partner, parent, or child) military deployment to a foreign country.

Contact the EDD PFL program by visiting State Disability Insurance (edd.ca.gov/disability), or by phone at 1-877-238-4373, or through the California Relay Service at 711.

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

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

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

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