PERSONNEL RECORD

(Form to be completed by employee)

DATE

NAME OF FACILITY

FACILITY ADDRESS

FACILITY FILE NUMBER

1. PERSONAL

NAME (LAST FIRST MIDDLE)

TELEPHONE ( )

ADDRESS

ARE YOU 18 YEARS OF AGE OR OLDER? ☐ YES ☐ NO IF NO, PLEASE STATE YOUR AGE

SOCIAL SECURITY NUMBER: (VOLUNTARY FOR ID ONLY) - -

DATE OF LAST PHYSICAL EXAMINATION

DATE OF LAST TB TEST

HAVE YOU EVER BEEN EMPLOYED UNDER A DIFFERENT NAME? ☐ YES ☐ NO IF YES, PLEASE LIST ALL NAMES USED.

DO YOU POSSESS A VALID CALIFORNIA DRIVER'S LICENSE? ☐ YES ☐ NO

CDL NUMBER

HAS YOUR DRIVER'S LICENSE EVER BEEN SUSPENDED OR REVOKED? ☐ YES ☐ NO

IF YES, PLEASE EXPLAIN ON BACK OF FORM.

NEAREST LIVING RELATIVE – NAME: TELEPHONE NUMBER RELATIONSHIP

ADDRESS

2. POSITION

TITLE SALARY HOURS DATE OF EMPLOYMENT

NAME OF SUPERVISOR

3. PREVIOUS EMPLOYMENT *(List most recent experience first. If additional space is needed, please attach a separate page.)*

NAME AND ADDRESS OF EMPLOYER	TELEPHONE NUMBER	JOB TITLE AND TYPE OF WORK	REASON FOR LEAVING	DATES FROM	DATES TO

4. EDUCATION

CIRCLE HIGHEST YEAR COMPLETED

6 7 8 9 10 11 12

DIPLOMA

CURRENTLY ENROLLED IN HIGH SCHOOL COMPLETION COURSE?

☐ NO ☐ YES IF YES, GIVE EXPECTED COMPLETION DATE_____

EMPLOYMENT – RELATED EDUCATION COURSES

COURSE TITLE	NAME OF SCHOOL OR ORGANIZATION AND ADDRESS	NUMBER UNITS COMPLETED	DATE COMPLETED	CURRENTLY ENROLLED

(OVER)

4. EDUCATION (Continued)

NAME UNIVERSITY, COLLEGE OR BUSINESS SCHOOL AND ADDRESS	MAJOR SUBJECT	NO. OF YEARS COMPLETED	NO. OF UNITS COMPLETED	DIPLOMA DEGREE OR CERTIFICATE	DATE COMPLETED

5. REFERENCES

List names of three persons who can give information about your background, character, abilities, etc.

NAME	ADDRESS	TELEPHONE NUMBER	RELATIONSHIP TO YOU (FRIEND, EMPLOYER, ETC.)

6. PROFESSIONAL AND TECHNICAL QUALIFICATIONS

A. List Licenses or Certificates of Competence held:

B. Names of Professional Associations of which you are a member:

NOTES:

I hereby certify under penalty of perjury that the above statements are true and correct. I give my permission for any necessary verification.

SIGNATURE OF EMPLOYEE | DATE

STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES
COMMUNITY CARE LICENSING DIVISION

HEALTH SCREENING REPORT - FACILITY PERSONNEL

All personnel, including applicant, licensee or employed staff of Residential Care Facilities for the Elderly, Community Care or Child Care Facilities must demonstrate that their health condition allows them to perform the type of work required. This health appraisal is to be completed by or under the direction of a physician.

A health screening, by or under the direction of a physician must have been performed not more than one year prior to employment or within seven (7) days after employment.

FACILITY NAME

FACILITY ADDRESS

PERSON'S NAME

AGE

POSITION TITLE

TYPE OF FACILITY

WORK DAYS PER WEEK

WORK HOURS PER DAY

DUTY STATEMENT

TYPES OF PERSONS SERVED *(Check appropriate items)*

- ☐ Infants
- ☐ Adults
- ☐ Developmentally Disabled
- ☐ Physically Handicapped
- ☐ Children
- ☐ Elderly
- ☐ Mentally Disordered
- ☐ Drug/Alcohol Addiction
- ☐ Other *(specify)*

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I HEREBY AUTHORIZE THE RELEASE OF MEDICAL INFORMATION CONTAINED IN THIS REPORT.

SIGNATURE OF APPLICANT/LICENSEE OR EMPLOYEE ▶

ADDRESS

DATE

NOTE TO PHYSICIAN: *Personnel in Residential Care Facilities for the Elderly, Community Care or Child Care Facilities shall be free from communicable disease, and capable of performing assigned tasks. Please complete the following information on the above named person.*

EVALUATION OF GENERAL HEALTH

EVALUATION OF ABILITY TO PERFORM WORK DESCRIBED IN THE ABOVE DUTY STATEMENT

NOTE ANY HEALTH CONDITION THAT WOULD CREATE A HAZARD TO THE PERSON, CLIENTS, CHILDREN OR OTHER PERSONNEL

DATE OF T.B. TEST

☐ POSITIVE

☐ NEGATIVE

ACTION TAKEN (IF POSITIVE)

DATE OF HEALTH SCREENING

NAME OF PHYSICIAN (PHYSICIAN'S STAMP)

DATE

HEALTH SCREENING BY: (ORIGINAL SIGNATURE) ▶

TELEPHONE #

DATE

Required Immunizations for JUMP Preschool, Inc. Employees

Wednesday, August 23, 2017

I, _____, am employed by JUMP Preschool, Inc. at 3327 Kenora Dr. Spring Valley, CA. I have been employed here since _____. Under the provisions of Section 1 (Section 1596.7995) of the Health and Safety Code:

Commencing September 1, 2016, a person shall not be employed or volunteer at a day care center if he or she has not been immunized against influenza, pertussis, and measles. Each employee and volunteer shall receive an influenza vaccination between August 1 and December 1 of each year.

- ☐ I am providing proof of pertussis vaccination
- ☐ I am providing proof of measles vaccination (or titer test which measures the existence and level of antibodies to measles in the blood.

- ☐ I am providing proof of influenza vaccination

OR

- ☐ I am providing a written statement from my licensed physician declaring that because of my physical condition or medical circumstances, the influenza immunization is not safe

OR

- ☐ I am providing a written statement from my licensed physician that I have current immunity to any or all of the above (influenza, pertussis, and measles).

OR

- ☐ I am submitting the following written declaration that I decline to have the influenza vaccination. I understand this exemption applies only to the influenza vaccine.

I, _____ decline to have the influenza vaccination.

Signed:_____ Date: _____

STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES
COMMUNITY CARE LICENSING

EVALUATION OF TEACHER QUALIFICATIONS

The courses listed below have been reviewed and verified by the Department of Social Services, Community Care Licensing Division, as meeting the requirements for child care center teachers in the California Code of Regulations, Title 22, Division 12.

The original of this form, along with copies of transcripts or other relevant documentation, must be kept in the teacher's personnel file at the licensed center. This form is transferable to other centers and will be accepted by all District Offices.

I. PERSONAL INFORMATION	COMPONENTS	FACILITY NUMBER
TEACHER:	☐ Preschool	
FACILITY:	☐ Infant	
ADDRESS:	☐ School-Age	
	☐ Mildly Ill Child	

II. EDUCATION/EXPERIENCE

☐ Children's Center Permit (Copy attached.)

☐ Child Development Associate Credential (Copy attached.)

☐ Regional Occupational Program Certificate (Copy attached.)

☐ Coursework only and six months of experience (Copy of transcripts attached.)

III. QUALIFYING POSTSECONDARY COURSES

COURSEWORK IN CD/ECE	COURSE #	UNITS (S/Q)	COLLEGE/UNIVERSITY
CHILD/HUMAN GROWTH AND DEV.			
CHILD, FAMILY AND COMMUNITY			
PROGRAM/CURRICULUM			
OTHER: INFANT, SCHOOL-AGE, ETC.			
TOTAL:			
ADDITIONAL UNITS REQUIRED:			

IV. QUALIFYING EXPERIENCE

FROM	TO	HOURS PER DAY	POSITION(S)	EMPLOYER(S)/ADDRESS(ES)	TOTAL: MO/DAY/YR

V. OTHER APPLICABLE EDUCATION/COURSES (based on statutory/regulatory changes) (Backup documentation attached.)

COURSE TITLE	DATE COMPLETED	VERIFIED BY
CPR		
First Aid		
Others		

Was an exception granted? ☐ No ☐ Yes (Copy of exception attached.)

Based on the completion of the requirements identified above, this employee is approved as a :

☐ Fully qualified preschool teacher _____
LPA'S SIGNATURE/PRINTED NAME AND DISTRICT OFFICE — DATE

☐ Fully qualified infant teacher _____
LPA'S SIGNATURE/PRINTED NAME AND DISTRICT OFFICE — DATE

☐ Fully qualified school-age teacher _____
LPA'S SIGNATURE/PRINTED NAME AND DISTRICT OFFICE — DATE

☐ Fully qualified mildly ill child teacher _____
LPA'S SIGNATURE/PRINTED NAME AND DISTRICT OFFICE — DATE

CHILD CARE CENTER COPY (ORIGINAL)

CRIMINAL RECORD STATEMENT

State law requires that persons associated with licensed facilities be fingerprinted and disclose any conviction. A conviction is any plea of guilty or nolo contendere (no contest) or a verdict of guilty. The fingerprints will be used to obtain a copy of any criminal history you may have.

Have you ever been convicted of a crime in California ? . . . . . ☐ YES ☐ NO

You need not disclose any marijuana-related offenses covered by the marijuana reform legislation codified at Health and Safety Code sections 11361.5 and 11361.7.

Have you ever been convicted of a crime from another state, federal court, military or jurisdiction outside of U.S.? . . . . . ☐ YES ☐ NO

Criminal convictions from another State or Federal court are considered the same as criminal convictions in California.

If you answer YES, give details on the back of this page indicating the nature and circumstances of each crime and the date and the location in which each crime occurred.

You must disclose convictions, including reckless and drunk driving convictions even if:

1. It happened a long time ago;
2. It was only a misdemeanor;
3. You didn't have to go to court (your attorney went for you);
4. You had no jail time or the sentence was only a fine or probation;
5. You received a certificate of rehabilitation;
6. The conviction was later dismissed, set aside or the sentence was suspended.

NOTE: IF THE CRIMINAL BACKGROUND CHECK REVEALS ANY CONVICTION(S) THAT YOU DID NOT DISCLOSE ON THIS FORM, YOUR FAILURE TO DISCLOSE THE CONVICTION(S) WILL RESULT IN AN EXEMPTION DENIAL, LICENSE APPLICATION DENIAL, LICENSE REVOCATION, OR EXCLUSION FROM A LICENSED FACILITY.

I declare under penalty of perjury under the laws of the State of California that I have read and understand the information contained in this affidavit and that my responses and any accompanying attachments are true and correct.

FACILITY NAME		FACILITY NUMBER	
YOUR NAME *(PRINT CLEARLY)*	YOUR ADDRESS	CITY	ZIP
SOCIAL SECURITY NUMBER *(SEE PRIVACY STATEMENT ON REVERSE SIDE)*	DATE OF BIRTH	DMV LICENSE NUMBER	
SIGNATURE		DATE	

I. Instructions to Respondents:

If you have been convicted of a crime in California, another state or in federal court, provide the following information:

(You need not disclose any marijuana-related offenses covered by the marijuana reform legislation codified at Health and Safety Code sections 11361.5 and 11361.7.)

What was the offense? _____

In which state and city did you commit the offense? _____

When did this occur? _____

Tell us what happened. (Use additional sheets of paper if needed) _____

I certify under penalty of perjury that the above information is true and correct to the best of my knowledge.

Signature _____ ***Date*** _____

II. Instructions to Licensees:

If the person discloses a criminal conviction, review the person's statement and discuss it with your Licensing Program Analyst (LPA). Maintain this form in your facility personnel file and send a copy to your LPA.

PRIVACY STATEMENT

Pursuant to the Federal Privacy Act (P.L. 93-579) and the Information Practices Act of 1977 (Civil Code section 1798 et seq.), notice is given for the request of the Social Security Number (SSN) on this form. The California Department of Justice uses a person's SSN as an identifying number. The requested SSN is voluntary. Failure to provide the SSN may delay the processing of this form and the criminal record check.

In order to be licensed, work at, or be present at, a licensed facility, the law requires that you complete a criminal background check. (Health and Safety Code sections 1522, 1568.09, 1569.17 and 1596.871) The Department will create a file concerning your criminal background check that will contain certain documents, including information that you provide. You have the right to access certain records containing your personal information maintained by the Department (Civil Code section 1798 et seq.). Under the California Public Records Act, the Department may have to provide copies of some of the records in the file to members of the public who ask for them, including newspaper and television reporters.

NOTE: IMPORTANT INFORMATION
The Department is required to tell people who ask, including the press, if someone in a licensed facility has a criminal record exemption. The Department must also tell people who ask, the name of a licensed facility that has a licensee, employee, resident, or other person with a criminal record exemption.

If you have any questions about this form, please contact your local licensing regional office.

REQUEST FOR LIVE SCAN SERVICE - COMMUNITY CARE LICENSING

Applicant Submission

1. ORI: **A0448**

2. Working Title: *(Check ✓ one)*
☐ Adult Resident other than Client ☐ Employee ☐ License, Certification, Applicant ☐ Volunteer

3. Authorized Applicant Type - Enter from list on Page 2, "DOJ Abbreviated CCLD Facility Type."

4. Agency Address Set Contributing Agency:

CA Dept of Social Services			**03502**
Agency authorized to receive criminal history information			Mail Code *(five-digit code assigned by DOJ)*
PO BOX 944243	**Mail Station 9-15-62**		**N/A**
Street No.	Street or PO Box		Contact Name *(Mandatory for all school submissions)*
Sacramento,	**CA**	**94244-2430**	**( ) N/A**
City	State	Zip Code	Contact Telephone No.

5. Applicant Information:

Name of Applicant: *(Please print)* LAST FIRST MI

AKA's: LAST FIRST

CDL No.

DOB: SEX: ☐ Male ☐ Female

Misc. No. BIL - AGENCY BILLING NUMBER *(IF APPLICABLE)*

HT: WT:

Misc. No.: ALIEN REGISTRATION, OUT OF STATE DRIVER'S LICENSE OR I.D.

EYE Color: HAIR Color:

Home Address: *(All applicants must complete)*

POB:

STREET OR PO BOX

SOC:
(See Privacy Statement on Page 4)

CITY, STATE AND ZIP CODE

6. Facility Number:

Level of Service ☑ DOJ ☑ FBI

If resubmission for fingerprint quality (select R2), list Original ATI No.

7. Employer: (*Additional response for Department of Social Services, DMV/CHP licensing, and Department of Corporations submissions only)*

Employer Name

Street No. Street or PO Box

Mail Code *(five digit code assigned by DOJ)*

City State Zip Code

Agency Telephone No. *(Optional)*

8.

Live Scan Transaction Completed By: Name of Operator Date

Transmitting Agency LSID# ATI No. Amount Collected/Billed

STATE OF CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

NOTICE

EMPLOYEE RIGHTS

Instructions:

This form is intended to meet the requirements of Health and Safety Code Sections 1596.881 and 1596.882 which require that employees be informed of their rights, at the time of employment, to filing complaints against their employer for violating any licensing law or regulation. The child care facility licensee is required to give the employee this form, to have the employee complete and detach the bottom of the form, and to maintain the signed acknowledgement of receipt of the form in the employee's file.

No employer shall discharge, demote, suspend or threaten to discharge, demote or suspend, or in any manner discriminate against any employee for taking any of the following actions:

1. Making an oral or written complaint against the employer to the California Department of Social Services or other agency having statutory responsibility for enforcement of the law or to the employer or representative of the employer for the violation of any licensing law or other laws (including but not limited to laws relating to child abuse, staff-child ratios, etc.).
2. Instituting or causing to be instituted any proceeding against the employer regarding the violation of any licensing law or other laws.
3. Is, or will be, a witness or testifier in a proceeding regarding the violation of any licensing law or other law.
4. Refusing to perform work that is in violation of a licensing law or regulation after notifying the employer of the violation.

Pursuant to Health and Safety Code Section 1596.882, an employee alleging the violation by the employer of any action described above shall do the following:

1. Present the employer with a claim alleging violation of the employee's rights within 45 days after the discharge, demotion, suspension or threat thereof or for discriminating against the employee for taking such action.
2. File a claim with the Division of Labor Standards Enforcement no later than 90 days after the employer takes any of the above described actions against the employee.

Upon receipt of the employee's complaint, the Division of Labor Standards Enforcement shall do whatever investigation it deems appropriate to resolve the complaint. If it is determined that the employer has violated the employee's rights, the Division of Labor Standards Enforcement shall take action against the employer in any appropriate court. The court shall have jurisdiction of any action taken as well as to issue restraining orders and any other appropriate relief, including rehiring and reinstatements of the employee to his or her former position with backpay and benefits.

Within 30 days of receipt of a complaint from an employee as outlined above, the Division of Labor Standards Enforcement shall review the facts of the complaint and set either a hearing date or notify the employee and the employer of its decision. Where necessary, the Division of Labor Standards Enforcement shall begin the appropriate court action to enforce the decision.

Except for any grievance procedure or arbitration or hearing that is available to the employee pursuant to a collective bargaining agreement, Section 1596.882 is the exclusive means for presenting claims.

To file a claim with the Division of Labor Standards Enforcement, check the white pages of the local telephone directory under State Government Offices, California State of, Industrial relations Department, Labor Standards Enforcement-Working Conditions, for the local telephone number and address of the nearest office, or contact the headquarters office at P.O. Box 603, San Francisco, CA 94101, telephone (415) 703-4810.

(Detach Here)

(This form is to be retained in the employee's file)

EMPLOYEE RIGHTS

This is to acknowledge that I _____ have received a copy of
(PLEASE PRINT NAME OF EMPLOYEE)

"EMPLOYEE RIGHTS" from my employer _____, who is the
(PLEASE PRINT NAME OF EMPLOYER)

licensee or authorized representative of _____
(PLEASE PRINT NAME OF FACILITY)

_____ _____
(SIGNATURE OF EMPLOYEE) (DATE)

STATEMENT ACKNOWLEDGING REQUIREMENT TO REPORT CHILD ABUSE

NOTE: RETAIN IN EMPLOYEE/LICENSEE FILE

NAME	
POSITION	FACILITY NUMBER

California law REQUIRES certain persons to report known or suspected child abuse. As a licensee or an employee at a licensed facility or a child care institution, YOU are one of those persons - a "mandated reporter."

PERSONS WHO ARE REQUIRED TO REPORT ABUSE

Mandated reporters include a licensee, an administrator, or an employee of a licensed community care or child day care facility. [Penal Code ("PC") § 11165.7(a)(10)] Mandated reporters also include an employee of a child care institution, including, but not limited to, foster parents, group home personnel, and personnel of residential care facilities. [PC § 11165.7(a)(14)] No supervisor or administrator may impede or inhibit an individual's reporting duties or subject the mandated reporter to any sanction for making the report. [PC § 11166(h)]

WHEN REPORTING ABUSE IS REQUIRED

A mandated reporter, who in his or her professional capacity, or within the scope of his or her employment, has knowledge of or observes a person under the age of 18 years whom he or she knows or reasonably suspects has been the victim of child abuse or neglect must report the suspected incident. The reporter must contact a designated agency immediately or as soon as practically possible by telephone, and shall prepare and send a written report within 36 hours of receiving the information concerning the incident. [PC § 11166(a)]

ABUSE THAT MUST BE REPORTED

Physical injury inflicted by other than accidental means on a child. [PC § 11165.6]

Sexual abuse meaning sexual assault or sexual exploitation of a child. [PC § 11165.1]

Neglect meaning the negligent treatment, lack of treatment, or the maltreatment of a child by a person responsible for the child's welfare under circumstances indicating harm or threatened harm to the child's health or welfare. [PC § 11165.2]

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

Unlawful corporal punishment or injury willfully inflicted upon a child and resulting in a traumatic condition. [PC § 11165.4]

WHERE TO CALL IN AND SEND THE WRITTEN ABUSE REPORT

Reports of suspected child abuse or neglect must be made to any police department or sheriff's department (not including a school district police or security department), county probation department, if designated by the county to receive mandated reports, or the county welfare department. [PC § 11165.9] The written report must include the information described in Penal Code section 11167(a) and may be submitted on form SS 8572.

IMMUNITY AND CONFIDENTIALITY OF REPORTER AND OF ABUSE REPORTS

Persons legally mandated to report suspected child abuse have immunity from criminal or civil liability for reporting as required or authorized by law. [PC § 11172(a)] The identity of a mandated reporter is confidential and disclosed only among agencies receiving or investigating reports, and other designated agencies. [PC § 11167(d)(1)] Reports are confidential and may be disclosed only to specified persons and agencies. Any violation of confidentiality is a misdemeanor punishable by imprisonment, fine, or both. [PC § 11167.5(a)-(b)]

PENALTY FOR FAILURE TO REPORT ABUSE

A mandated reporter who fails to make a required report is guilty of a **misdemeanor** punishable by up to six months in jail, a fine of $1000, or both. [PC § 11166(b)]

COPY OF THE LAW

Prior to my employment in a licensed community care or child day care facility, or child care institution, my employer provided me with a copy of Penal Code sections 11165.7, 11166, and 11167. [PC § 11166.5(a)]

ACKNOWLEDGMENT OF RESPONSIBLITY

I, _____, have knowledge of my responsibility to report known or suspected child abuse in compliance with Penal Code section 11166. [PC § 11166.5(a)]

SIGNATURE	DATE

EMPLOYEE EMERGENCY CONTACT FORM

Name _____

Personal Contact Info:

Home
Address_____

City, State, ZIP

_____

Home Telephone # _____ Cell # _____

Emergency Contact Info:

(1)
Name_____Relationship_____

Address

_____

City, State, ZIP

_____

Cell # _____Work Telephone # _____

(2) Name_____Relationship_____

Address

_____

City, State, ZIP

_____

Cell # _____Work Telephone # _____

Medical Contact Info:

Doctor Name. _____ Phone #

_____

Employee Signature _____ Date

_____

NOTICE TO EMPLOYEE

Labor Code section 2810.5

EMPLOYEE

Employee Name: _____

Start Date: _____

EMPLOYER

Legal Name of Hiring Employer: _____

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):

_____

Physical Address of Hiring Employer's Main Office:

_____

Hiring Employer's Mailing Address (if different than above):

_____

Hiring Employer's Telephone Number: _____

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: _____

Physical Address of Main Office: _____

Mailing Address: _____

Telephone Number: _____

WAGE INFORMATION

Rate(s) of Pay: _____ Overtime Rate(s) of Pay: _____

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

□ Other (provide specifics): _____

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

If yes, are all rate(s) of pay and bases thereof contained in that written agreement? □ 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: _____

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

2020

Step 1: Enter Personal Information

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

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

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

Step 2: Multiple Jobs or Spouse Works

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

Do **only one** of the following.

(a) Use the estimator at *www.irs.gov/W4App* for most accurate withholding for this step (and Steps 3–4); **or**

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

(c) If there are only two jobs total, you may check this box. Do the same on Form W-4 for the other job. This option is accurate for jobs with similar pay; otherwise, more tax than necessary may be withheld . . . . . ▶ ☐

TIP: To be accurate, submit a 2020 Form W-4 for all other jobs. If you (or your spouse) have self-employment income, including as an independent contractor, use the estimator.

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

Step 3: Claim Dependents

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

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

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

Add the amounts above and enter the total here . . . . . **3** $

Step 4 (optional): Other Adjustments

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

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

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

Step 5: Sign Here

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

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

▶ _____ **Date**

Employers Only

Employer's name and address	First date of employment	Employer identification number (EIN)

Employment Eligibility Verification

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

USCIS
Form I-9
OMB No. 1615-0047
Expires 08/31/2019

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

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

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

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

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

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

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

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

☐ 1. A citizen of the United States

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

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

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

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

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

QR Code - Section 1
Do Not Write In This Space

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

Preparer and/or Translator Certification (check one):

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

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

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

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

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

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

STOP *Employer Completes Next Page* STOP

Employment Eligibility Verification

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

USCIS
Form I-9
OMB No. 1615-0047
Expires 08/31/2019

Section 2. Employer or Authorized Representative Review and Verification

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

Employee Info from Section 1	Last Name *(Family Name)*	First Name *(Given Name)*	M.I.	Citizenship/Immigration Status

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

Additional Information

QR Code - Sections 2 & 3
Do Not Write In This Space

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

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

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

Last Name of Employer or Authorized Representative	First Name of Employer or Authorized Representative	Employer's Business or Organization Name

Employer's Business or Organization Address (Street Number and Name)	City or Town	State	ZIP Code

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

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

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

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

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

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

JUMP Preschool Inc. Employment Contract

This contract, dated on the ____ day of _____ in the year 20____, is made between JUMP Preschool Inc. and . of Spring Valley, California. This document constitutes an employment agreement between these two parties and is governed by the laws of California.

WHEREAS the Employer desires to retain the services of the Employee, and the Employee desires to render such services, these terms and conditions are set forth.

IN CONSIDERATION of this mutual understanding, the parties agree to the following terms and conditions:

1. **Employment**

The Employee agrees that he or she will faithfully and to the best of their ability carry out the duties and responsibilities communicated to them by the Employer. The Employee shall comply with all company policies, rules and procedures at all times.

2. **Position**

As a _____, it is the duty of the Employee to perform all essential job functions and duties. From time to time, the Employer may also add other duties within the reasonable scope of the Employee's work.

3. **Compensation**

As compensation for the services provided, the Employee shall be paid a wage of $_____ per hour and will be subject to a bi-annual performance review. All payments shall be subject to mandatory employment deductions (State & Federal Taxes, Social Security, Medicare).

4. **Benefits**

The Employee has the right to participate in any benefits plans offered by the Employer. The employer currently offers : we do not offer no medical, dental or retirement benefits. Access to these benefits will only be possible after the probationary period has passed.

5. **Probationary Period**

It is understood that the first 30 days of employment constitutes a probationary period. During this time, the Employee is not eligible for paid time off or other benefits. During this time, the Employer also exercises the right to terminate employment at any time without advanced notice.

6. **Paid Time Off**

Following the probationary period, the Employee shall be eligible for the following paid time off:

- Christmas week- at the 1 year mark
- 1 week summer - after 1 year mark
- 3 paid for sick/personal days
- Bereavement leave *may* be granted if necessary.

The employer reserves the right to modify any paid time off policies.

7. **Termination**

It is the intention of both parties to form a long and mutually profitable relationship. However, this relationship may be terminated by either party at any time provided 2 week notice by employee and immediate termination by JUMP Preschool Inc. A written notice is delivered to the other party.

The Employee agrees to return any Employer property upon termination.

8. Non-Competition and Confidentiality

As an Employee, you will have access to confidential information that is the property of the Employer. You are not permitted to disclose this information outside of the Company.

During your time of Employment with the Employer, you may not engage in any work for another Employer that is related to or in competition with the Company. You will fully disclose to your Employer any other Employment relationships that you have and you will be permitted to seek other employment provided that (a.) it does not detract from your ability to fulfill your duties, and (b.) you are not assisting another organization in competing with the employer.

It is further acknowledged that upon termination of your employment, you will not solicit business from any of the Employer's clients for a period of at least 12 month.

9. Entirety

This contract represents the entire agreement between the two parties and supersedes any previous written or oral agreement. This agreement may be modified at any time, provided the written consent of both the Employer and the Employee.

10.Legal Authorization

The Employee agree that he or she is fully authorized to work in the United States and can provide proof of this with legal documentation. This documentation will be obtained by the Employer for legal records.

11.Severability

The parties agree that if any portion of this contract is found to be void or unenforceable, it shall be struck from the record and the remaining provisions will retain their full force and effect.

12.Jurisdiction

This contract shall be governed, interpreted, and construed in accordance with the laws of California, San Diego.

In witness and agreement whereof, the Employer has executed this contract with due process through the authorization of official company agents and with the consent of the Employee, given here in writing.

_____ _____

Employee Signature **Date**

_____ _____

Company Official Signature **Date**

Dear New Staff Member,

Welcome to JUMP Preschool & Kindergarten. We are happy that you have joined us a member of our team. We are excited about the personal experiences, expertise and special touch that only you can bring to the program.

You have been hired because you have demonstrated that you are qualified based on your experience and education in the field of Early Childhood Education. Because we have precious young children in our care and will only accept the very best for their care and learning we require all new hires go through a 30 day probation period.

The determining factor is based on the results of a parent questioner and a score of 80% or better on our Probationary Rating scale.

At the date scheduled, as of your first day of work, you and the director will meet to discuss the outcome of these two factors to determine if your probationary period was successful.

At your three month anniversary you are considered a permanent employee. Permanent employees will receive a paid week during the summer program. Please note that seniority to select week off goes to the longest employee and down the line.

Probationary Period
Start Date _____

Probationary Period
End Date _____

Date scheduled for Director Determination Meeting _____

Date of Permanent Employment (qualification for paid week each summer) _____