

MVSD Certificated Substitute Onboarding CHECK LIST

*Please make sure to email Human Resources; Shannon Bassi at sbassi@mvschools.org for a brief appointment time to drop of the **completed forms listed below** or if you have any questions regarding the paper work*

Documents to bring to HR onboarding	Completed	Notes
MCOE Sub ID Verification	<input type="checkbox"/>	Provide to HR
Current CA ID; SS card	<input type="checkbox"/>	Bring Originals
Oath of Affirmation	<input type="checkbox"/>	
W-4 Federal Tax Form	<input type="checkbox"/>	
DE-4 State Tax Form	<input type="checkbox"/>	
I-9 Employment	<input type="checkbox"/>	
STRS Election Form/ SS 1945 Form/ STRS beneficiary form	<input type="checkbox"/>	*STRS beneficiary form optional
Child Abuse Form	<input type="checkbox"/>	
Technology Agreement	<input type="checkbox"/>	
Race Data Collection Form	<input type="checkbox"/>	
Signed ACA Notification	<input type="checkbox"/>	
Notice to EE- Labor Code Section 2810.5	<input type="checkbox"/>	
State Disability Insurance notice	<input type="checkbox"/>	
Substitute Profile Info sheet	<input type="checkbox"/>	
Completed online trainings	<input type="checkbox"/>	*Please email sbassi@mvschools.org to be set up for training.
Subfinder information	<input type="checkbox"/>	Keep for your records
Workers Comp information card provided	<input type="checkbox"/>	Keep for your records

MILL VALLEY SCHOOL DISTRICT
411 Sycamore Avenue, Mill Valley, CA 94941

Per Article 20, Section 3 of the California Constitution, all public employees shall, before they enter upon the duties of their respective offices, take and subscribe the following oath or affirmation:

OATH OR AFFIRMATION OF ALLEGIANCE FOR PUBLIC EMPLOYEES

I, _____, do solemnly swear (or affirm) that I will support and defend the Constitution of the United States and the Constitution of the State of California against all enemies, foreign and domestic; that I will bear true faith and allegiance to the Constitution of the United States and the Constitution of the State of California; that I take this obligation freely, without any mental reservation or purpose of evasion; and that I will well and faithfully discharge the duties upon which I am about to enter.

Signature: _____

Certified by: _____
(Signature of person who administers oath)

_____ Human Resources Specialist _____
(Position)

Form W-4 (2016)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Personal Allowances Worksheet (Keep for your records.)

A	Enter "1" for yourself if no one else can claim you as a dependent	A	_____
B	Enter "1" if: { • You are single and have only one job; or • You are married, have only one job, and your spouse does not work; or • Your wages from a second job or your spouse's wages (or the total of both) are \$1,500 or less. }	B	_____
C	Enter "1" for your spouse. But, you may choose to enter "-0-" if you are married and have either a working spouse or more than one job. (Entering "-0-" may help you avoid having too little tax withheld.)	C	_____
D	Enter number of dependents (other than your spouse or yourself) you will claim on your tax return	D	_____
E	Enter "1" if you will file as head of household on your tax return (see conditions under Head of household above)	E	_____
F	Enter "1" if you have at least \$2,000 of child or dependent care expenses for which you plan to claim a credit	F	_____
G	Child Tax Credit (including additional child tax credit). See Pub. 972, Child Tax Credit, for more information. • If your total income will be less than \$70,000 (\$100,000 if married), enter "2" for each eligible child; then less "1" if you have two to four eligible children or less "2" if you have five or more eligible children. • If your total income will be between \$70,000 and \$84,000 (\$100,000 and \$119,000 if married), enter "1" for each eligible child	G	_____
H	Add lines A through G and enter total here. (Note: This may be different from the number of exemptions you claim on your tax return.) ▶	H	_____

For accuracy, complete all worksheets that apply.
 { • If you plan to itemize or claim adjustments to income and want to reduce your withholding, see the Deductions and Adjustments Worksheet on page 2.
 • If you are single and have more than one job or are married and you and your spouse both work and the combined earnings from all jobs exceed \$50,000 (\$20,000 if married), see the Two-Earners/Multiple Jobs Worksheet on page 2 to avoid having too little tax withheld.
 • If neither of the above situations applies, stop here and enter the number from line H on line 5 of Form W-4 below.

----- Separate here and give Form W-4 to your employer. Keep the top part for your records. -----

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

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
City, State, and ZIP Code	<input type="checkbox"/> SINGLE or MARRIED (with two or more incomes) <input type="checkbox"/> MARRIED (one income) <input type="checkbox"/> HEAD OF HOUSEHOLD

- 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 2016 _____
 OR
- Additional amount of state income tax to be withheld each pay period (if employer agrees), Worksheet C _____
 OR
- 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 Account Number
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----- 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:

- 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,
- 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.



Employment Eligibility Verification

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

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

▶ **START HERE.** Read instructions carefully before completing this form. The instructions must be available during completion of this form.
ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers **CANNOT** specify which document(s) they will accept from an employee. The refusal to hire an individual because the documentation presented has a future expiration date may also constitute illegal discrimination.

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

Last Name (Family Name)		First Name (Given Name)		Middle Initial	Other Names Used (if any)		
Address (Street Number and Name)			Apt. Number	City or Town		State	Zip Code
Date of Birth (mm/dd/yyyy)	U.S. Social Security Number		E-mail Address			Telephone Number	

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

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

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

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

1. Alien Registration Number/USCIS Number: _____

OR

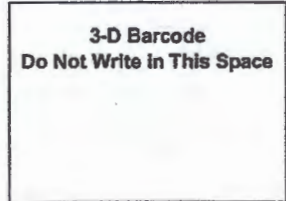
2. Form I-94 Admission Number: _____

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

Foreign Passport Number: _____

Country of Issuance: _____

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



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

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

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



Employer Completes Next Page



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 examine a combination of one document from List B and one document from List C as listed on the "Lists of Acceptable Documents" on the next page of this form. For each document you review, record the following information: document title, issuing authority, document number, and expiration date, if any.)

Employee Last Name, First Name and Middle Initial from Section 1:

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:		<div style="border: 1px solid black; padding: 10px; width: fit-content; margin: auto;"> <p>3-D Barcode Do Not Write in This Space</p> </div>		
Issuing Authority:				
Document Number:				
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):				

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		Date (mm/dd/yyyy)	Title of Employer or Authorized Representative	
Last Name (Family Name)		First Name (Given Name)	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) Last Name (Family Name) First Name (Given Name) Middle Initial	B. Date of Rehire (if applicable) (mm/dd/yyyy):
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C. If employee's previous grant of employment authorization has expired, provide the information for the document from List A or List C the employee presented that establishes current employment authorization in the space provided below.

Document Title:	Document Number:	Expiration Date (if any)(mm/dd/yyyy):
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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:	Date (mm/dd/yyyy):	Print Name of Employer or Authorized Representative:
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Permissive Membership

ES0350 (Rev. 1/16)

CALSTRS

California State Teachers' Retirement System
 P.O. Box 15275, MS 17
 Sacramento, CA 95851-0275
 800-228-5453
 CalSTRS.com

PERMISSIVE ELECTION AND ACKNOWLEDGEMENT OF RECEIPT OF CALSTRS DEFINED BENEFIT PLAN MEMBERSHIP INFORMATION

An employee who performs creditable service (Education Code Section 22119.5), and who is excluded from mandatory membership pursuant to Section 22601.5, 22602, or 22604, may elect membership in the California State Teachers' Retirement System (CalSTRS) Defined Benefit Program at any time while employed to perform creditable service. If you elect membership below, then your election becomes irrevocable until you terminate employment and receive a full refund of your accumulated contributions.

EMPLOYEE CERTIFICATION

NAME (LAST, FIRST, INITIAL)		CLIENT ID OR SOCIAL SECURITY NUMBER	
MAILING ADDRESS		POSITION TITLE	
CITY, STATE, ZIP CODE		HOME TELEPHONE	
E-MAIL ADDRESS			
<p>I certify that I have received information from my employer on my eligibility to elect membership in CalSTRS Defined Benefit Program and that I am making the following election. I fully understand this election is irrevocable and applies to all future creditable service performed for all CalSTRS covered employers until I terminate employment and refund my CalSTRS contributions.</p> <p>I understand it is a crime to fail to disclose a material fact or to make any knowingly false material statements for the purpose of altering a benefit administered by CalSTRS and it may result in penalties, including restitution, up to one year in jail and a fine of up to \$5,000 (Education Code Section 22010).</p>			
I elect membership <input type="checkbox"/>		I decline membership at this time <input type="checkbox"/>	
SIGNATURE		DATE	

TO BE COMPLETED BY EMPLOYER

I certify that the above-named employee has been provided with the membership criteria for the CalSTRS Defined Benefit (DB) Program and was informed within 30 days of hire that they may elect membership in the Program at any time while employed to perform creditable service. (Education Code Section 22455.5). I understand this form, containing the above-named employee's election, must be on file with CalSTRS before contributions can be submitted into the program.

OFFICIAL'S SIGNATURE		TITLE					
COUNTY (or Other Employing Agency) MARIN		DISTRICT MILL VALLEY SCHOOL DISTRICT					
EMPLOYEE #	SEX		BIRTHDAY (MM/DD/YY)	MEMBERSHIP DATE (MM/DD/YY)	ASSIGNMENT		
	MALE	FEMALE			FT	PT	SUB



ES0350

ES350 • REV 1/16

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

Employee Name _____ Employee ID# _____
Employer Name Mill Valley School District Employer ID# 68-0194373

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

Windfall Elimination Provision

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

Government Pension Offset Provision

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

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

For More Information

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

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

Signature of Employee _____ Date _____

Recipient Designation Form

One-Time Death Benefit/Cash Balance Lump-Sum Payment

(MS 0002, rev 01/13)

CALSTRS
California State Teachers' Retirement System
P.O. Box 15275, MS 43
Sacramento, CA 95851-0275
800-228-5453
CalSTRS.com

This form is for designating recipients to receive the death benefits payable in the event of your death under the CalSTRS Defined Benefit Program and the Cash Balance Benefit Program. Print clearly in dark ink or type all information requested and initial any corrections.

Check one of the following:

- I am a member of the Defined Benefit Program. My recipient designation is for the one-time death benefit payable upon my death.
- I am a participant of the Cash Balance Benefit Program. My recipient designation is for the lump-sum payment to be distributed upon my death.
- I am a member/participant of both the Defined Benefit and Cash Balance programs. My recipient designation is for the lump-sum death benefits payable under both programs. (Refer to instructions if recipients are different between programs.)

I hereby revoke any previous designations and designate the following primary recipients—or their survivors—to receive equal amounts, unless otherwise specified as recipients for any benefits payable under the Teachers' Retirement Law at the time of my death. If I survive the primary recipients, I designate the secondary recipients—or their survivors—to share equally unless otherwise specified as recipients for any benefits under law at the time of my death. If I survive all of my named recipients, then any benefit payable at the time of my death will be paid to my estate. I understand this form does not designate a recipient to receive a continuing monthly retirement benefit.

Return your signed form to: CalSTRS • P.O. Box 15275, MS 43 • Sacramento, CA 95851-0275 • Fax 916-414-5783 or 916-414-5784 • For faster processing, complete and submit this form on *myCalSTRS*.

Section 1: Member/Participant Information

NAME (LAST, FIRST, INITIAL)

CLIENT ID OR SOCIAL SECURITY NUMBER

MAILING ADDRESS

DATE OF BIRTH (MM/DD/YYYY)

()

CITY

STATE

ZIP CODE

HOME TELEPHONE

EMAIL ADDRESS

Section 2: Primary Recipients

Use this area to designate one or more *primary* recipients to receive a death benefit.

Use additional sheets if needed. 

FULL NAME OF PERSON, TRUST OR ORGANIZATION

()

MAILING ADDRESS

TELEPHONE

CITY

STATE

ZIP CODE

Person – Relationship: _____

Male

Female

SOCIAL SECURITY NUMBER/TAXPAYER ID NUMBER/EMPLOYER ID NUMBER

Organization – Contact Name: _____

DATE OF BIRTH/TRUST DATE (MM/DD/YYYY)

Trust

PERCENTAGE

Estate

(MUST TOTAL 100% FOR ALL PRIMARY RECIPIENTS)



MS0002

Section 2: Primary Recipients *continued*

FULL NAME OF PERSON, TRUST OR ORGANIZATION _____ ()

MAILING ADDRESS _____ TELEPHONE _____

CITY _____ STATE _____ ZIP CODE _____

Person – Relationship: _____
 Male Female SOCIAL SECURITY NUMBER/TIN/EIN _____

Organization – Contact Name: _____ DATE OF BIRTH/TRUST DATE (MM/DD/YYYY) _____

Trust PERCENTAGE _____

Estate (MUST TOTAL 100% FOR ALL PRIMARY RECIPIENTS)

FULL NAME OF PERSON, TRUST OR ORGANIZATION _____ ()

MAILING ADDRESS _____ TELEPHONE _____

CITY _____ STATE _____ ZIP CODE _____

Person – Relationship: _____
 Male Female SOCIAL SECURITY NUMBER/TIN/EIN _____

Organization – Contact Name: _____ DATE OF BIRTH/TRUST DATE (MM/DD/YYYY) _____

Trust PERCENTAGE _____

Estate (MUST TOTAL 100% FOR ALL PRIMARY RECIPIENTS)

Section 3: Secondary Recipients

Use this area to designate one or more *secondary* recipients to receive a death benefit should all of your primary recipients predecease you. Use additional sheets if needed.

FULL NAME OF PERSON, TRUST OR ORGANIZATION _____ ()

MAILING ADDRESS _____ TELEPHONE _____

CITY _____ STATE _____ ZIP CODE _____

Person – Relationship: _____
 Male Female SOCIAL SECURITY NUMBER/TIN/EIN _____

Organization – Contact Name: _____ DATE OF BIRTH/TRUST DATE (MM/DD/YYYY) _____

Trust PERCENTAGE _____

Estate (MUST TOTAL 100% FOR ALL SECONDARY RECIPIENTS)



MS0002

Section 3: Secondary Recipients continued

FULL NAME OF PERSON, TRUST OR ORGANIZATION

MAILING ADDRESS

()

TELEPHONE

CITY

STATE

ZIP CODE

Person – Relationship: _____
 Male Female

SOCIAL SECURITY NUMBER/TIN/EIN

Organization – Contact Name: _____

DATE OF BIRTH/TRUST DATE (MM/DD/YYYY)

Trust

Estate

PERCENTAGE

(MUST TOTAL 100% FOR ALL SECONDARY RECIPIENTS)

Check this box if additional recipients are listed on an attachment. Identify each as *primary* or *secondary* and the percentages. Percentages must total 100% for all recipients.

Section 4: Required Signatures

Check all that apply.

- I am married or registered as a domestic partner and both our signatures are below.
- I am married or registered as a domestic partner and my spouse or partner did not sign below. I have completed and signed the *Justification for Non-Signature of Spouse or Registered Domestic Partner* section on the next page.
- I have never been married or in a registered domestic partnership, or I am widowed or my partner has died.
- I have been divorced or terminated a registered domestic partnership and my former spouse or partner was awarded a portion of my CalSTRS benefits.
- I have been divorced or have terminated a registered domestic partnership and my former spouse or partner was *not* awarded a portion of my CalSTRS benefits.

I certify under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

I understand that perjury is punishable by imprisonment for up to four years (Penal Code section 126).

I understand it is a crime to fail to disclose a material fact or to make any knowingly false material statements for the purpose of altering a benefit administered by CalSTRS and it may result in penalties, including restitution, up to one year in jail and a fine of up to \$5,000 (Education Code section 22010).

MEMBER'S SIGNATURE

DATE (MM/DD/YYYY)

SPOUSE'S OR REGISTERED DOMESTIC PARTNER'S SIGNATURE

DATE (MM/DD/YYYY)

SPOUSE'S OR PARTNER'S PRINTED NAME (LAST, FIRST, INITIAL)

SPOUSE'S OR PARTNER'S SOCIAL SECURITY NUMBER

SPOUSE'S OR PARTNER'S DATE OF BIRTH (MM/DD/YYYY)



MS0002

Justification for Non-Signature of Spouse or Registered Domestic Partner

As required by Education Code sections 22453 and 26703, any request related to the selection of benefits by a member in which spousal or registered domestic partner interest may be present requires the signature of the spouse or registered domestic partner unless one of the following conditions exist. If you are married or registered as a domestic partner and your spouse or partner does not sign this form, you must check the appropriate box indicating the reason your spouse or partner did not sign.

- I do not know and have taken all reasonable steps to determine the whereabouts of my spouse or registered domestic partner.
- My spouse or registered domestic partner is incapable of executing the acknowledgment because of an incapacitating mental or physical condition.
- My current spouse or registered domestic partner has no identifiable community property interest in the benefits.
- My spouse or registered domestic partner and I have executed a settlement agreement that makes the community property law inapplicable to the marriage or registered domestic partnership.
- My spouse or registered domestic partner has refused to sign the acknowledgment. Court action will be or has been initiated to enforce or waive the signature requirement for my spouse or partner. (CalSTRS must have a certified copy of the court order before any designation can be made. Submit a certified copy of the court order when you receive it.) Education Code sections 22454 and 26704

I certify under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

I understand that perjury is punishable by imprisonment for up to four years (Penal Code section 126).

I understand it is a crime to fail to disclose a material fact or to make any knowingly false material statements for the purpose of altering a benefit administered by CalSTRS and it may result in penalties, including restitution, up to one year in jail and a fine of up to \$5,000 (Education Code section 22010).



MEMBER'S SIGNATURE

SIGNATURE DATE (MM/DD/YYYY)

If this form is not completely filled out, it will not be accepted and will be returned to you. Your current recipient status will not be updated. Review your form carefully before submitting:

- Did you designate at least one primary recipient and provide all the requested information?
- If you designated a trust, did you provide the name and date the trust was created? Do not provide your trust document at this time.
- If you designated percentages, do they equal 100 percent for your primary recipients and/or secondary recipients?
- Did you sign and date the form?
- If you are married or in a registered domestic partnership, did your spouse or partner sign and date the form?
- If you cannot obtain your spouse or partner's signature, did you complete, sign and date the *Justification for Non-Signature of Spouse or Registered Domestic Partner*?



MS0002



Child Abuse Reporting Statement

I, _____ acknowledge I have received a copy of Penal Code Sections 11165.7, 11166, and 11167. _____(Initials)

I have fully read and familiarized myself with the provisions of these sections, and have had the opportunity to have any of my questions about these provisions clarified.

I further understand the following:

- 1. Section 11166 of the Penal Code requires any child care custodian, health practitioner, employee of a child protective agency or child visitation monitor who has knowledge of or observes a child in his or her professional capacity or within the scope of his or her employment whom he or she knows or reasonably suspects has been the victim of a child abuse to report the known or suspected instance of child abuse to a child protective agency immediately or as soon as practically possible by telephone and to prepare and send a written report (fax or electronic transmission is permitted) thereof within 36 hours of receiving the information concerning the incident.
2. 'Child Care Custodian' includes teacher, instructional aides, administrative officers, supervisors of child welfare and attendance, or certificated pupil personnel of any public or private school; administrators of a public or private day camp; licensees, administrators and employees of community care facilities or child day care facilities licensed to care for children; headstart teachers; licensing workers; or licensing evaluators; public assistance workers; employees of a child care institution including, but not limited to foster parents, group home personnel, and personnel of residential care facilities; and social workers, probation officers, or parole officers.
3. 'Health Practitioner' includes physicians and surgeons, psychiatrists, psychologists, dentist, residents, interns, podiatrists, chiropractors, licensed nurses, dental hygienists, optometrists, or any other person who is licensed under Division 2 (commencing with Section 500) of the Business and Professions Code or emergency medical technicians I or II, paramedics, or other persons certified pursuant to Division 2.5 (commencing with Section 1797) of the Health and Safety Code; psychological assistants registered pursuant to Section 2913 of the Business and Professions Code, and Marriage, Family and Child Counselors.
4. Section 11165.7 of the Penal Code includes definitions of 'mandated reporter' by position.
5. Section 11167 of the Penal Code protects the confidentiality of any child abuse report I make and that my identity as a reporter will only be shared among agencies receiving or investigating mandated reports and that the agency receiving my report shall not disclose my identity to my employer except with my consent or by court order.

As an employee of _____, I certify that I have read and understood this statement and will comply with my obligations under the child abuse reporting law.

Print Name

Signature

Date

Department

MILL VALLEY SCHOOL DISTRICT
Electronic Information Services
TERMS AND CONDITIONS

The Mill Valley School District (District) may provide electronic-information services (EIS) to all personnel who are employed by the District. Employees who use EIS services must sign an EIS user's agreement. EIS includes networks (internet), databases, e-mail (both school supplied addresses and private addresses originating from District computers), Broadband, Cell phone (District supplied), text messages, websites maintained by the District, digital storage, instant messaging, internet-based voice communications, or other electronic sources. The uses of any or all of these services while on duty or on District-provided equipment shall be in support of education, research, and the educational goals of the District.

The District requires anyone who is granted the privilege to use the District's EIS services must agree in writing to follow these guidelines and procedures for appropriate use. If a user violates any of these provisions, the privilege may be terminated and future access will be denied. Your signature is legally binding and indicates that you have read the terms and conditions carefully, and understand their significance.

Employee use of EIS services is a privilege granted to individual employees at the discretion of the District. Employees do not have any expectation of privacy for e-mails and other messages sent through the District's EIS system or equipment. The District may log the use of all systems and monitor all system utilization. Employee understands that any and all information, including personal e-mails, on the District's e-mail and other message, with the exception of student records, is not deemed private and is potentially a public record. Contents of personal folders, PC hard drives, and e-mail may be monitored and occasionally read. The District reserves the right to discipline employees when there is evidence that suggests that employee has either repeatedly or grossly violated the terms and procedures of this agreement.

The District does recognize employees' rights to First Amendment freedom of expression in the content of messages and other communications sent through the system. The District will make every effort to protect the privacy of employee's electronic communication and storage devices, unless there is clear evident that suggests that this agreement has been violated. Accounts may be suspended and inappropriate files may be deleted at the discretion of the District or its representative. The District is not responsible for any service interruptions, loss or corruption of data, changes, or consequences of changes to the system. The District also reserves the right to establish rules and regulations to ensure the efficient operation of the EIS.

1. **Acceptable Use** – The uses of any or all of the EIS services while on duty or on District-provided equipment shall be in support of education, research, and the educational goals of the District. Employees not provided a primary computer, for their personal use, may only use workstations designated by the site administrator as publicly accessible.

2. **Unacceptable Use** – Transmission of any material in violation of any federal or state regulation is prohibited. This includes, but is not limited to: copyrighted material, threatening, harassing or obscene material, known viruses, spam, or material protected by trade secret. Use for commercial activities, product advertisement or political lobbying is prohibited. Any transmission or reception of pornographic or "Adult" material that is inappropriate for children is expressly prohibited.

While users are not responsible for items of this kind that they receive unsolicited and involuntarily, they are expected to delete inappropriate e-mail, programs, photos, movies or other material in prompt fashion and report repeated violations by spammers or senders of inappropriate materials to the system administrator within three days of receipt and being opened on the system.

The use of INTERNET and electronic mail is a privilege, and any unacceptable use will result in a cancellation of those privileges.

3. **Network Etiquette** – Users are expected to abide by the generally accepted rules of network etiquette. These include, but are not limited to, the following:

- Be polite
- Use appropriate language
- Do not reveal your personal address or phone numbers, or those of fellow users or colleagues
- Note that electronic mail (e-mail) is not guaranteed to be private. Messages relating to or in support of illegal activities may be reported to the authorities or can be used as grounds for discipline
- Do not use the network in any way that you would disrupt the use of the network by other users
- Comply with and cooperate with the system administrators
- Use a consistent, traceable identity on all District computers unless the use serves a clear pedagogical purpose. In such cases, the system administrator should be notified of the alternate identity and its purpose
- Appropriation of another individual’s known identity or attempts to use names or other identifying characteristic that would reasonably confuse others is prohibited
- Users may not attempt to circumvent the District’s online filtering system to get access to sites identified as inappropriate for District use
- Links to the District, District addresses or sites, and to your District e-mail address on non-District computers or sites should be cleared with the Superintendent or his or her designee
- Users shall not use District EIS services for personal commercial gain
- Users may not file share copyrighted materials with others
- All communications and information accessible via the network should be assumed to be private property

4. The Mill Valley School District makes no guarantees of any kind, whether expressed or implied, for the service it is providing. The Mill Valley School District will not be responsible for any damages you suffer; this includes loss of data resulting from delays, non-deliveries, misdeliveries or service interruptions caused by its own negligence or user errors or omissions. Use of any information obtained via the INTERNET is at the user’s own risk.

5. District employees are required to comply with the Family Education and Privacy Rights Act of 1974 (FERPA) 20 USC 1232 g which prohibits the disclosure of personally identifiable information from student records without express written permission from parents. Exchange of such information electronically can be a violation of FERPA.

6. **Security** – Security on any computer system is a high priority, especially when the system involves many users. If a user can identify a security problem on the INTERNET, the Director of Technology should be notified promptly. Attempts to log in to any INTERNET system as a system administrator will result in cancellation of user’s privileges.

7. **Vandalism** – Vandalism will result in cancellation of privileges. Vandalism is defined as any malicious attempt to harm, destroy or misrepresent data of another user, agency or other networks that are connected. This includes, but is not limited to, the uploading or creation of computer viruses.

Print Name

User’s Signature

Date

Race and Ethnicity Data Collection

To comply with the U.S. Department of Education and the CA Department of Education the district is required to gather race and ethnicity information on all newly hired staff. Please fill out the information requested on this form and return to the Human Resources Department.

Identification Information:

Name: _____

Position: _____

Ethnicity Information:

Select one:

No, not Hispanic or Latino

Yes, Hispanic or Latino

Race Information:

The above part of the question is about ethnicity, not race. No matter what you selected above please continue to answer the following by checking one or more boxes to indicate what you consider your race to be.

Select one or more:

American Indian or Alaskan Native

Asian

- Chinese
- Japanese
- Korean
- Vietnamese
- Asian Indian
- Laotian
- Cambodian
- Filipino
- Hmong
- Other Asian

Native Hawaiian or Other Pacific Islander

- Hawaiian
- Guamanian
- Samoan
- Tahitian
- Other Pacific Islander

Black or African American

White



Administrative Office
411 Sycamore Avenue
Mill Valley, CA 94941
Tel (415) 389-7700
Fax (415) 389-7773

October 1, 2013

HEALTH CARE REFORM: The Public Health Insurance Market Place

As your employer, we are required to provide you with certain information about the Affordable Care Act (also known as "Health Care Reform"). This notice contains general information about the ability to purchase medical coverage through a Public Marketplace.

The Affordable Care Act (ACA) was signed into law by President Obama in 2010. This law provides changes in the way employers offer health insurance to their employees who are not already enrolled in a health insurance program and will become effective January 1, 2014.

The required notice provides background information as to how this new law will be implemented and applies primarily to those who are not currently eligible for health insurance through the Mill Valley School District. The notice explains something called the "Health Insurance Marketplace," otherwise known as the California Health Benefits Exchange, and how it provides options for those employees who are eligible to participate in the ACA program.

Also, below we have added some information we thought would be helpful. Please carefully read all pages of this memo.

What you need to know

1. Almost everyone must have medical coverage by January 1, 2014 or pay a tax penalty

- You may get your medical coverage through:
 - Our employer-sponsored group health plan,
 - A spouse's employer-sponsored group health plan (if available), or
 - An individual policy
- You may purchase an individual policy in the private market or through the Public Marketplace in your state

2. You should carefully evaluate your coverage options

You may hear about the state Public Marketplaces through the media and other advertisements announcing that you can locate coverage through the Public Marketplace as of October 1, 2013. You may also receive advertisements from insurance companies marketing policies.

3. Before declining our group health plan coverage, evaluate your options carefully

If I get medical coverage from:		
	Our Employer Plan	A Public Marketplace
Who is eligible for coverage?	<ul style="list-style-type: none"> ➤ Represented certificated and classified employees who are subject to the applicable MVTA or CSEA Collective Bargaining Agreements; non-bargaining unit employees, Confidential & management employees who are eligible to receive the District contribution to medical benefits (contribution is prorated for less than full-time employees) ➤ All employees working at least 30 hours per week or grandfathered in who are not eligible for the District contribution to medical benefits 	<p>For eligibility or other questions:</p> <p>Call the Covered California Information Line at 1-888-975-1142</p> <p>Visit www.coveredca.com</p> <p>Additional information regarding Health Care Reform can be found at: www.healthcare.gov</p>
Who pays for coverage?	You and/or your employer	You
How do I pay for costs?	May be with pre-tax income (Section 125)	After-tax income
How much does it cost?	Contact Mary Bowles, Payroll Specialist, mbowles@mvschools.org	<p>Call the Covered California Information Line at 1-888-975-1142</p> <p>Visit www.coveredca.com</p> <p>Additional information regarding Health Care Reform can be found at: www.healthcare.gov</p>
What level of benefits is offered?	Our medical plans all meet or exceed the plans offered through the Public Marketplace.	You choose a 'Bronze', 'Silver', 'Gold', or 'Platinum' level of coverage
Will the government pay for any of my coverage?	No	Only if you qualify for a federal subsidy. The District's employer-sponsored plan is designed to meet the minimum value and affordability standards set by the Affordable Care Act, which would generally prevent you from qualifying for a subsidy.

For more information:

- Contact Mary Bowles, Payroll Specialist at mbowles@mvschools.org for information about our employer-sponsored medical coverage
- Call the Covered California Information Line at 1-888-975-1142
- Visit www.coveredca.com
- Additional information regarding Health Care Reform can be found at www.healthcare.gov.
- If your household income falls below 138% of the Federal Poverty Level, you may be eligible for Medicaid - Contact your State Medicaid office for more information

Questions regarding the Public Marketplace should be addressed by the public marketplace for the state in which you reside.

X

Signature

Date

NOTICE TO EMPLOYEE

Labor Code section 2810.5

EMPLOYEE

Employee Name: _____

Start Date: _____

EMPLOYER

Legal Name of Hiring Employer: Mill Valley School District

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:
411 Sycamore Ave. Mill Valley, CA 94941

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

Hiring Employer's Telephone Number: 415-389-7700

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: _____

WORKERS' COMPENSATION

Insurance Carrier's Name: York Ins. Services Group
Address: One Upper Pond Road Building F-4th Floor, Parsippany, NJ 07054
Telephone Number: 925-349-3886, 866-391-9675 (corporate)
Policy No.: _____
 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): _____

ACKNOWLEDGEMENT OF RECEIPT

(Optional)

(PRINT NAME of Employer representative)

(PRINT NAME of Employee)

(SIGNATURE of Employer Representative)

(SIGNATURE of Employee)

(Date)

(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.



Administrative Office
411 Sycamore Avenue
Mill Valley, CA 94941
Tel (415) 389-7700
Fax (415) 389-7773

I fully understand that I am not covered by State Disability Insurance through the Mill Valley School District.

The District offers disability insurance through American Fidelity, AFLAC and The Standard (certificated employees only) and has been made available to me on a voluntary basis. I have received information regarding the various plans and have chosen not to apply at this time

Name _____ Date _____

Signature _____

MILL VALLEY SCHOOL DISTRICT
CERTIFICATED SUBSTITUTE EMPLOYEE PROFILE

NAME _____ SSN# _____

ADDRESS _____ CITY _____ ZIP _____

HOME PHONE _____ CELL PHONE _____

(One of these phone #s becomes your "Access code" in the system. Please circle the one you'd like us to use.)

EMAIL _____

STRS Member ____ Yes ____ No Retired Teacher ____ Yes ____ No

Subjects for which you are qualified and/or want to substitute.

Elementary School

____ Pre-Kindergarten ____ Kindergarten ____ 1st - 3rd ____ 4th - 5th ____ Roving Sub

____ Kindergarten Aide (paid at sub teacher rate) ____ P.E. ____ Art

____ RSP ____ Special Ed. Aide (paid at sub teacher rate)

Mill Valley Middle School (6th-8th)

____ Art ____ Language Arts ____ Math/Algebra ____ Science

____ P.E. ____ Soc. Studies ____ Roving Sub ____ Music

____ RSP ____ Special Ed. Aide (paid at teacher substitute rate)

____ Librarian ____ Foreign Language ____ Campus Supervisor

LOCATION

Elementary

____ Old Mill ____ Edna Maguire ____ Park School

____ Strawberry Point ____ Tam Valley

____ Mill Valley Middle School

Please indicate any days/times of the week that you are **unavailable**.

District Use Only:

Start Date: _____

DE 34 ____
MA ____
REAP ____
MR 87 ____
W-4 ____



Administrative Office
411 Sycamore Ave
Mill Valley, CA 94941
tel (415) 389 7700
fax (415) 389 7773

ABSENCE SYSTEM REGISTRATION INSTRUCTIONS
(Smart Find Express – SFE)

MVSD Substitute User Instructions

Call 380-2471 and follow the prompts:

1. Enter your ACCESS ID no area code (7 digit phone number) followed by the Star Key (*).
2. When the system asks for a “PIN” number re-enter your Access ID no area code (7 digit phone number) followed by the Star Key (*).
3. The system will then prompt you to voice your name.
4. The system will then ask you to change your PIN number. You choose a number at least 6 (six) digits and enter it followed by the Star Key (*).

When logging in to the website, your PIN number is called a Password

After registering with the system, you may also call the number above or log on to the website to review your profile, update your phone call back number or change your email, change your pin number or review your jobs. If the system has your email listed, you will be notified of your pending jobs.

After registering via telephone you may access the substitute system via the web by logging on to <https://sems.mvschools.org>.

Should you have any questions, please call Mary Bowles at the Mill Valley School District Office at 389 7703 or email mbowles@mvschools.org.



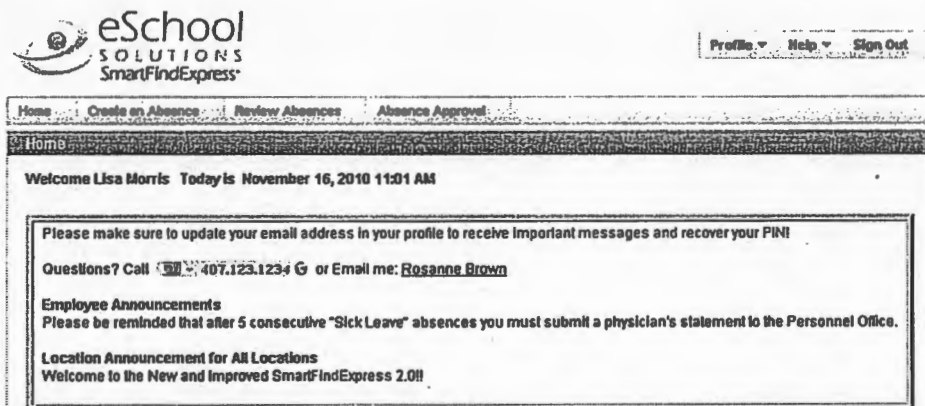
<https://semd.mvschools.org>

The Mill Valley School District as implemented a web based version of eSchool Solutions sub finder system called SmartFindExpress (SFE). The new version is very similar to what you are accustomed to using, however, there are changes including a new look. The changes are designed to expand absence and substitute management capabilities.

The Log In Screen has a new look –

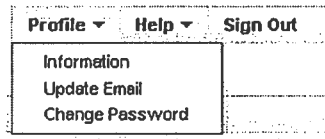


The Home Page is very similar to what you are familiar with, however the menus have been moved from the left side of the screen to across the top of the screen –



(over)

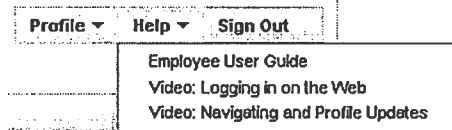
The Profile Menu at the top right side of the screen –



Will allow you to:

- View the status and address in your profile
- Add or modify the email address in your profile
- Change your Password (PIN)

The Help Menu provides you with access to an Employee User Guide you can elect to view online or download and even print as well as access to training videos to assist you in navigating the system (check back often as new videos will continue to be added) –



Call the hotline 24/7 to report your work related injury and receive immediate medical advice.



INJURY CARE DIRECT™

Call the hotline 24/7 to report your work related injury and receive immediate medical advice.