COUNTY OF RIVERSIDE
HUMAN RESOURCES DEPARTMENT

EMPLOYMENT DECLARATION FORM

Name (Last, First, Middle Initial)	Social Security Number	Telephone

Physical Address (Street/P.O. Box, City, Postal Code

Mailing Address if Different (Street/P.O. Box, City, Postal Code	Driver's License Number, Class, and Exp. Date

Department	Position Title	Employee ID (if available)

Are you retired under the California Public Employees Retirement System (CalPERS)? ☐ No ☐ Yes

Are you enrolled with the California Public Employees Retirement System (CalPERS) as a result of working for another CalPERS employer? ☐ No ☐ Yes

List All Previous Names Under Which You Have Been Employed	Language(s) other than English in which you are fluent:

Employment of Relatives: No employee may execute direct supervision over or initiate or participate in decisions (including but not limited to initial employment, retention, evaluation, promotion, or work assignments) specifically pertaining to another County of Riverside employee who is related as spouse, father, mother, brother, sister, son, daughter, son-in-law, daughter-in-law, father-in-law, mother-in-law, brother-in-law, sister-in-law, or the equivalent through registered domestic partnership (County of Riverside Salary Ordinance, Ord. No. 440).

List all close relatives, as defined above, and the Agency or Department in which they work. Do not specify the relationship.

DECLARATION

By my signature below, I declare that all information provided on this Employment Declaration Form and all documentation submitted for employment to the County of Riverside is true and complete. I understand that falsification of information is grounds for disqualification or termination if hired. I authorize the County of Riverside and its agents to verify any information related to my Employment Declaration Form or continued employment with the County of Riverside and I authorize the release of any such information. I release the County and its agents from any and all liability for damage of whatever kind for seeking such information.

Signature _____ Date _____

The information you provide in this section is voluntary and confidential. It will be used for statistical reporting only.

Gender: ☐ Male ☐ Female

Are you a Veteran of the United States Armed Forces with an honorable discharge having served during an expeditionary period or declared war? ☐ No ☐ Yes

Ethnic/Racial Group (Indicate one with which you most closely identify):

☐ Hispanic or Latino
☐ White (Not Hispanic or Latino)
☐ Black or African American (Not Hispanic or Latino)
☐ Native Hawaiian/Pacific Islander (Not Hispanic or Latino)
☐ American Indian/Alaskan Native (Not Hispanic or Latino)
☐ Asian (Not Hispanic or Latino)
☐ Two or More Races (Not Hispanic or Latino)

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 (**Note:** Do **not** include child support payments. See Pub. 503, Child and Dependent Care Expenses, for details.)	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

▶ **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.**

OMB No. 1545-0074

2016

1 Your first name and middle initial	Last name	2 **Your social security number**	
Home address (number and street or rural route)		3 ☐ Single ☐ Married ☐ 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.** ▶ ☐	
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 10 only if sending to the IRS.)	9 Office code (optional)	10 Employer identification number (EIN)

CalPERS

NOTICE OF EXCLUSION FROM CalPERS MEMBERSHIP

1. SOCIAL SECURITY NUMBER	Your employer has contracted with the California Public Employees' Retirement System (CalPERS) to provide an employee benefit package which includes service retirement, death, and disability benefits.

2. CURRENT NAME (LAST) (FIRST) (MIDDLE)

3. NAME OF PUBLIC AGENCY	4. DEPARTMENT OR SCHOOL DISTRICT	5. JOB OR POSITION TITLE
County of Riverside	HR-TAP	Temporary Assistant

6. TERM OF APPOINTMENT	7. IF TEMPORARY, ENTER NEAREST NUMBER OF WHOLE MONTHS THE APPOINTMENT IS EXPECTED TO LAST.	8. APPOINTMENT DATE MM	DD	YYYY
☐ PERMANENT ☒ TEMPORARY	6 MONTHS			

9. TIME BASE

☐ FULL-TIME ☒ INDETERMINATE ☐ PART-TIME IF PART TIME, ENTER THE FRACTION OF FULL TIME:

In your present position with this agency, you are excluded from CalPERS membership because:

☐ 1. Your full-time seasonal or limited term appointment is limited to 6 months or less.

☐ 2. Your part-time appointment is limited to less than an average of 20 hours per week for less than one year.

☐ 3. Your appointment is an on-call, intermittent, emergency, substitute, or other irregular basis which excludes you from membership until you have worked 1,000 hours (or 125 days if paid on per diem basis) this fiscal year.

☒ 4. Your position is excluded by law or by contract agreement which excludes:
Per Diem
Enter contract exclusion (for Public Agencies only).

☐ 5. You are an independent contractor.

☐ 6. You are employed to render professional legal service to a city.
Exceptions: Persons holding the office of city attorney, deputy city attorney, or assistant city attorney.

☐ 7. You are employed as a student aide by a school district in a position established for students only and you are attending school in the same district (for County Schools only).

NOTE: If you are a member of CalPERS by previous employment (either you have funds on deposit or service credit), exclusions 1, 2, and 3 do not apply to you and you should be a member in your present position. Be sure to notify your employer to complete a (PERS-1) Member Action Request Form or appoint via ACES to report your employment to CalPERS.

If you believe that your employment <u>does</u> qualify you for CalPERS membership, ask your employer for an explanation. If you still have doubts, you may appeal directly to CalPERS by sending a letter to the Actuarial & Employer Services Branch, Membership Analysis & Design Unit, P.O. Box 942709, Sacramento, CA 94229-2709, stating the reasons why you feel you should be a member.

SIGNATURE OF CERTIFYING OFFICER	TITLE	DATE
SIGNATURE OF EMPLOYEE		DATE

NOTE: Benefits provided by CalPERS are described in the "CalPERS Benefits" information booklet available from your employer.

California Public Employees' Retirement System
Customer Account Services Division
Retirement Account Services Section
P.O. Box 942709
Sacramento, CA 94229-2709
TTY: (877) 249-7442
888 CalPERS (or 888-225-7377) phone · (916) 795-3005 fax
www.calpers.ca.gov

MEMBER RECIPROCAL SELF-CERTIFICATION FORM

Complete the following information and return this form to your Personnel Office ***within 10 business days:***

EMPLOYEE NAME: _____
(Last) *(First)* *(Middle)*

SOCIAL SECURITY NUMBER OR CalPERS ID NUMBER: _____

NAME OF MOST RECENT RECIPROCAL RETIREMENT SYSTEM: _____

PERMANENT SEPARATION DATE FROM MOST RECENT RECIPROCAL RETIREMENT SYSTEM: _____

FIRST MEMBERSHIP DATE IN ANY PRIOR CALIFORNIA PUBLIC RETIREMENT SYSTEM THAT IS SUBJECT TO RECIPROCITY: _____

(Check the applicable statement)

_____ I have not been a member of another California Public Retirement System within the last six months.

_____ I was a member and am retired from the _____ Retirement System and subsequently became employed by a CalPERS-covered employer.

_____ I was a member of the _____ Retirement System and became employed by a CalPERS-covered employer within six months after separating from employment with the previous reciprocal retirement system.

I understand that by accepting employment in a specific retirement system, I am subject to the applicable laws and regulations of that system. I also understand that completing this form does not constitute a request to establish reciprocity. I must complete and return the "Election to Coordinate Retirement When Changing Retirement Systems," (PERS-MSD-255) Form to CalPERS.

I hereby certify that the foregoing information is true and correct and any information found to be incorrect may require corrections to my account in the California Public Employees' Retirement System including, but not limited to, my date of membership. CalPERS may make any necessary corrections to my account to ensure I am properly enrolled and eligible to receive the correct retirement benefits.

_____ _____
SIGNATURE OF EMPLOYEE DATE

TO BE COMPLETED BY EMPLOYER ONLY:

NAME OF CalPERS AGENCY: _____

CalPERS BUSINESS PARTNER ID: _____

CalPERS MEMBERSHIP ELIGIBILITY DATE WITH YOUR AGENCY: _____

ORIGINAL HIRE DATE WITH YOUR AGENCY: _____

DATE MEMBER RECIPROCAL SELF-CERTIFICATION FORM GIVEN TO EMPLOYEE: _____
DATE MEMBER RECIPROCAL SELF-CERTIFICATION FORM RECEIVED FROM EMPLOYEE: _____

_____ _____ _____
(Please Print) DESIGNEE OF EMPLOYER TITLE DATE

_____
DESIGNEE'S SIGNATURE

Social Security Administration

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

Employee Name _____ Social Security # **Employee ID#** _____

Employer Name COUNTY OF RIVERSIDE **Employer ID#** 0067

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** _____

COUNTY OF Riverside
HUMAN RESOURCES
Winner IPMA Award for Excellence

401(A) PART-TIME & TEMPORARY EMPLOYEES' RETIREMENT PLAN
P.O. Box 1569 · Riverside, CA 92502-1569
(951) 955-4981, Option 2 · (951) 955-8538 FAX
RETIREMENT@RC-HR.COM · HTTP://BENEFITS.RC-HR.COM

TEMPORARY PLAN ELIGIBILITY SELF-CERTIFICATION FORM

Provide the following information

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

Employee ID #:_____ Date of Hire:_____

(Check the applicable statement)

☐ 1. I am not an active member of another public retirement system.

☐ 2. I am an active member of another public retirement system:

Name of public retirement system:_____

Name of employer: _____

Membership date in other public retirement system:_____

☐ 3. I am a retiree of a public retirement system.

Name of public retirement system:_____

Name of employer: _____

Membership date in other public retirement system:_____

I understand that participation in the County of Riverside 401(a) Part-Time and Temporary Employees' Retirement Plan (the "Plan") is required if you are designated as a Part-time, Seasonal or Temporary employee and you are excluded from participation in CalPERS. The Plan is offered in lieu of Social Security.

I acknowledge receipt of the Summary Plan Description ("SPD") for the County of Riverside Part-Time and Temporary Employees' Retirement Plan which is intended to provide a summary of the Plan and was also informed that I may obtain a copy of the SPD from the Human Resources website at http://benefits.rc-hr.com/. I acknowledge that eligibility into this plan is not permitted as a "rehired annuitant" governed under the Public Employees' Retirement Law (PERL); while participating under another retirement system maintained by the County of Riverside; or while working in a job classification that is excluded from participation. I may become eligible for the Plan if my employment status changes. It is my responsibility to notify the County if my eligibility to participate in the Plan changes at any time during the term of my employment.

I hereby certify that the foregoing information is true and correct and any information found to be incorrect may require corrections to my account in the Plan. The County of Riverside reserves the right to amend my account to ensure eligibility requirements are met in accordance with provisions in the Plan document or applicable Federal law.

_____ _____
Employee Signature Date

Employee # _____

County of Riverside
Part-Time & Temporary Employees' Retirement Plan

Retirement Unit
P.O. Box 1569
Riverside, CA 92502-1569

BENEFICIARY DESIGNATION FORM

I. Personal Information (please print all information on this form; use additional sheets as necessary)

Participant Name _____ Social Security Number _____ Date of Birth _____

Address _____ City _____ State _____ Zip code _____

Name, Relationship and Telephone Number of Closest Living Relative (Note: This Relative does not have to be named below as one of your Beneficiaries)

Name _____ Relationship _____ Telephone Number _____

II. Principal Beneficiary Designation (All Principal Beneficiaries who survive you shall share equally in any benefits payable upon your death unless you specify otherwise)

Name	Social Security Number	Relationship	Date of Birth	Share

III. Contingent Beneficiary Designation (the Contingent Beneficiary will be paid any benefits due should the Principal Beneficiary pre-decease you)

Name	Social Security Number	Relationship	Date of Birth	Share

I hereby revoke all previous Beneficiary designations, which I have made.

Participant's Signature _____ **Date** _____ **Spouse's Signature** _____ **Date** _____

COUNTY OF RIVERSIDE

DESIGNATION OF PERSON TO RECEIVE WARRANTS OR CHECKS UPON DEATH OF EMPLOYEE

PRINT OR TYPE (LAST NAME) (FIRST NAME) (INITIAL)

In the event of my death, I hereby designate the person named below as being entitled to receive all warrants or checks that will be payable to me by the County of Riverside.

NAME OF PERSON TO RECEIVE YOUR CHECKS IN CASE OF YOUR DEATH

Name: _____

FULL Address: _____

Relationship: _____ Soc.Sec.No.: _____
(REQUIRED)

Note: Identification documents will be required to be presented since warrants and checks can only be dispersed to your designee after sufficient proof of identity is provided.

_____ _____
Signature Date

_____
Employee ID

UPON DEATH OF EMPLOYEE - Government Code 53245

Any person now or hereafter employed by the County may file with his/her appointing power a designation of a person who, notwithstanding any other provisions of law, shall on the death of the employee, be entitled to receive all warrants or checks that would have been payable to the descendent had he/she survived. The employee may change the designation from time to time. A person so designated shall claim such warrants or checks from the appointing power. A person who received a warrant or check pursuant to this section is entitled to negotiate it as if he/she were the payee.

IMPORTANT: Please fill out the above information completely. We cannot accept an incomplete form. Please return to:

HUMAN RESOURCES/ EMPLOYEE SERVICES – MAIL STOP #1150
or
P. O. BOX 1569, RIVERSIDE, CA 92502-1569

9/21/2009

FAXES ARE NOT ACCEPTED

AUDITOR CONTROLLER
COUNTY OF RIVERSIDE

DIRECT DEPOSIT REQUEST FORM

You are limited to three (3) accounts and may add one additional for TreasuryDirect bonds.

Employee ID (required)	Department
	TAP
Last Name	**First Name**

CHECKING ACCOUNTS

Complete the checking account section only and attach a voided check for each checking account listed.

Bank Name	Routing #	Account Number	% of Net Pay	Dollar Amount
Skylight ONE Pay Card				

SAVINGS ACCOUNTS

Complete the savings account section only and attach documentation from the bank for each account listed.

Bank Name	Routing #	Account Number	% of Net Pay	Dollar Amount

TREASURY DIRECT SAVINGS BONDS

Complete this section to have funds deposited with the US Treasury to purchase savings bonds. You must attach a copy of your Treasury Direct documentation which includes your routing and account #.

Routing #	Account Type		Account #	Amount
051736158	Checking Account	X		

I authorize the County of Riverside to initiate deposits (credits) and/or corrections to the financial institutions indicated herein. The financial institution is authorized to credit and/or correct the amounts to my account. This authority will remain in full force and effect until the County has received written notification from me in the form of a revised authorization, canceling this authorization in such time and such manner as to afford the County and depositor a reasonable opportunity to act on it. I understand it may take up to three (3) pay periods for this authorization to become effective during which time I will receive a mailed warrant (check). No mark outs or alternation to this paragraph will be accepted.

Employee Signature (required)	Date
Please enter a phone # that you can be reached at during the hours of 7:30AM - 5:00PM. If we are unable to contact you, processing of request may be delayed.	**Telephone Number**

AUDITOR-CONTROLLER USE ONLY

Pay Period Processed	Keyed By	Date Entered

MAIL STOP 1160 OR MAIL TO PO BOX 1326, RIVERSIDE, CA 92502

Revised 01/2013

EMPLOYEE ACKNOWLEDGEMENT OF THE MEDICAL PROVIDER NETWORK

In order to provide the most timely and suitable quality medical care in the event of an injury on the job, the County of Riverside has instituted a Medical Provider Network for Workers' Compensation.

The following procedures must be followed for all work related injuries and illnesses.

- Report promptly any work related injury to the supervisor.
- For a referral to a medical provider specialist, contact your Supervisor, Manager, or Claims Adjuster.
- Ensure all medical treatment is handled only through the MPN (Medical Provider Network) unless otherwise authorized.
- Direct all questions about the level of care to the PCP (Primary Care Physician), who is the focal point for all medical treatment.
- A directory of medical care providers is available at my request through the Workers' Compensation Division.

Please sign below to indicate that you have read and understand the procedures to follow in the event of an injury and your duties under our Medical Provider Network.

Print Name

Date

Employee Signature

County of Riverside
Employer

Employee Number

A COPY OF THE MPN DIRECTORY IS AVAILABLE FROM YOUR EMPLOYER OR ADJUSTER UPON YOUR REQUEST.

RECONOCIMIENTO DEL EMPLEADO DE LA MEDICAL PROVIDER NETWORK

Para brindar atención médica de la más rápida y de apropiada calidad en el evento de una lesión ocasionada en el trabajo, hemos instituido una Red de Proveedores Médicos para Compensación Laboral.

Los procedimientos siguientes deben ser seguidos para todas las lesiones y enfermedades ocasionadas en el trabajo.

- Reporte inmediatamente a su supervisor cualquier lesión ocasionada en el trabajo.
- Para una referencia a un médico especialista, comuníquese con su empleador o ajustador de reclamos.
- Cerciórese que todo tratamiento médico sea manejado únicamente por la MPN (Red de Proveedores Médicos), a menos que de otro modo autorizado
- Dirija toda pregunta sobre el nivel de cuidado al PCP (Primary Care Physician – Médico de Cabecera), quien es el punto de referencia para todo tratamiento médico.
- Un directorio de proveedores de cuidado médico está disponible al solicitarlo a través de mi empleador.

Por favor firmar abajo para indicar que usted ha leído y entendido los procedimientos que se siguen en el evento de una lesión y sus responsabilidades bajo nuestra Red de Proveedores Médicos.

Nombre en Imprenta

Fecha

Firma del Empleado

Empleador County of Riverside

Número del Empleado

UNA COPIA DEL DIRECTORIO DE LA MPN ESTA DISPONIBLE DE SU EMPLEADOR O AJUSTADOR AL SOLICITARLO.

AUTHORIZATION TO DRIVE RIVERSIDE COUNTY VEHICLE OR PRIVATE VEHICLE FOR COUNTY BUSINESS

X

Name (Last) (First) (Middle) Home Address (Street) (City) (Zip Code)

*Driver's License # State Class Expiration Date County Employee # (if available) Date of Birth

Dept. & Division Telephone # Job Title License Restrictions Are you required to wear corrective lenses or contacts? (If none, write no)

Have you been issued any tickets for moving violations within the past three (3) years? Yes ☐ No ☐
If yes, please explain _____

Have you had any vehicular accidents, regardless of fault, over the past three (3) Years? Yes ☐ No ☐
If yes, please explain _____
I hereby declare that I will:

a. Report immediately to my supervisor, manager or department head, all incidents or accidents involving a County of Riverside vehicle or my private vehicle that occurs during the course and scope of my employement: (BOS Policy D1. 6) I also agree to Complete a Confidential Report Form 942.6 available from the County of Riverside Safety Office Intranet Site, and also available on the County of Riverside Workforce Exchange website (**http://www.workforceexchange.net**) under the HR Toolbox banner
b. Inform my supervisor, manager or department head immediately if my license is amended, expired, suspended or revoked. (BOS Policy D1.6c)
c. Maintain the minimum vehicle liability insurance as required by the State of California for my private vehicle used during the course and scope of my employment; if my private vehicle is registered/licensed out of the State of California, I will obtain insurance equal to or greater than the minimum vehicle liability insurance required by the State of California for any private vehicle used while in the course and scope of County business. (BOS Policy D-1.6b)
d. Maintain routine general maintenance on vehicle and operate my private vehicle in a safe operating condition. (Safety Manual Document 4001, III Vehicle Safety Guidelines)
e. Operate a County owned vehicle in a manner that is safe and in accordance with the California Vehicle Code and the County directives/policies. Said policies are: Automotive Fleet Policy and Regulations, Salary Ordinance 440 & Safety Manual Document 4001.

I understand that failure to do any of the above may result in disciplinary action.
I acknowledge that my personal insurance is primary when using my private vehicle on County business; that I am responsible for all deductible(s) of my personal insurance. (BOS Policy D-1. 6b)

I hereby acknowledge the County may from time to time request and/or review my Department of Motor Vehicles driving record and I hereby authorize release of said information.

Signature of Employee _____ Date _____

☐ I hereby authorize the above named individual to drive a County or private vehicle in accordance with the California drivers license class for which the individual is licensed. I also acknowledge that I have verified that the employees' personal vehicle is insured in compliance with requirements of the State of California. (D. 6b)

Signature _____ Date _____
Department Head / Designee

☐ I hereby cancel this authorization effective:

Signature _____ Date _____
Department Head / Designee

General Form 30 (Rev 4/10/13) Distribution – Original to Safety Office, Mail Stop # 2170 *Attach copy of current Driver's License* Copy to Department Copy to Employee

COUNTY OF RIVERSIDE
PARKING PERMIT REQUEST
DRIVER IDENTIFICATION

LAST NAME: _____ FIRST NAME: _____ MI: _____

DEPARTMENT NO: 277 DEPARTMENT NAME: TAP

COUNTY EMPLOYEE NO: NEW WORK PHONE NO: 955-9178

VEHICLE IDENTIFICATION

MAKE: _____ MODEL: _____ YEAR: _____

COLOR: _____ LICENSE PLATE NO: _____ STATE: _____

PREVIOUS PERMIT ISSUED: NO____ YES____ IF YES, PERMIT NO: _____

THIS VEHICLE NO: _____

REPLACEMENT DECAL

THIS PERMIT IS TO REPLACE PERMIT NO: _____

OLD PERMIT REMOVED BY: _____ DATE: _____

OTHER (*PLEASE EXPLAIN*) _____

I CERTIFY THE ABOVE INFORMATION TO BE TRUE AND FURTHER UNDERSTAND THAT THIS PARKING PERMIT IS TO BE USED BY MYSELF AND AUTHORIZES PARKING IN DESIGNATED COUNTY EMPLOYEES AREAS ONLY. I WILL REMOVE THIS DECAL AND SURRENDER IT TO FACILITIES MANAGEMENT UPON SELLING THIS VEHICLE OR EMPLOYMENT TERMINATION.

_____	Temporary Assistant	_____
EMPLOYEE SIGNATURE	**TITLE**	**DATE**

I CERTIFY THE ABOVE NAME INDIVIDUAL IS EMPLOYED BY THIS AGENCY OR DEPARTMENT AND AUTHORIZED A COUNTY PARKING DECAL IN ACCORDANCE WITH ESTABLISHED COUNTY POLICY.

_____	_____	_____
DEPARTMENT HEAD SIGNATURE	**TITLE**	**DATE**

_____ PURSUANT TO RESOLUTION ADOPTED BY THE COUNTY BOARD OF SUPERVISORS, AND THE REQUEST OF THE AGENCY/DEPARTMENT HEAD, YOU ARE HEREBY AUTHORIZED TO A PARKING PERMIT TO PARK IN DESIGNATED COUNTY EMPLOYEE PARKING AREAS ONLY.

_____ REQUEST DENIED FOR THE FOLLOWING REASON: _____

_____	_____
Mark McGinnis	**DATE**

FACILITIES MANAGEMENT USE ONLY

PERMIT NO ISSUED: _____ DATE: _____ ISSUED BY: _____

Parking Structure address is 4293 Orange St. Riverside
Phone #: 951-955-5129