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\*CAL ARNGR 690-3  
CA ANGR 40-03

STATE OF CALIFORNIA  
OFFICE OF THE ADJUTANT GENERAL  
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Sacramento, California 95821

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11 February 1987

Civilian Personnel  
STATE CIVIL SERVICE PERSONNEL

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\*This regulation supersedes CAL ARNGR 690-3/CA ANGR 1 March 1983

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#### SECTION I - GENERAL

1. **PURPOSE.** This regulation prescribes policies and procedures for the administration of State Civil Service personnel appointed under the provisions of the State of California Government Code and State Personnel Board and Department of Personnel Administration rules. This regulation is not applicable to personnel on State Active Duty under the provisions of the California Military and Veterans Code and who are administered under CAL ARNGR 600-1/CA ANGR 36-10.

#### SECTION II - POSITIONS

2. **PERMANENT POSITIONS.** a. Civil Service permanent positions are established in the various divisions of the Military Department and the several field activities of the California Army and Air National Guard to perform duties properly classifiable under the State Civil Service System. Civil Service position titles and grades are based on job specifications established by the Department of Personnel Administration and generally include the following:

(1) Clerical, Administrative, and Data Processing positions at the Office of the Adjutant General (OTAG), Training Sites, and Air Bases.

(2) Trades positions at Training Sites, Air National Guard Bases and Stations.

(3) Custodial and Maintenance positions at OTAG, Training Sites, Armories, and Air National Guard Bases and Stations.

b. Authorized permanent State Civil Service positions are those positions listed in the Military Department State Budget.

3. **TEMPORARY POSITIONS.** Temporary positions may be established for short term employment, normally not to exceed six months duration. Position titles and

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grades of temporary positions will be based on duties and responsibilities required as compared to State Civil Service job specifications. Temporary positions can only be established within the Temporary Help personnel support established in the Military Department State Budget. Permanent Intermittent positions (on call when needed) are also established with temporary help personnel support.

**4. ESTABLISHING/RECLASSIFYING POSITIONS.** a. OTAG Form 900-21, State Civil Service Position Request, Appendix A to include full justification and a duty description will be submitted to establish or reclassify a State Civil Service position.

b. Requests should be submitted to Directorate of State Personnel Programs (CASS) in duplicate at least 90 days prior to the proposed effective date for permanent positions and 30 days prior to the proposed effective date for temporary positions. New positions that cannot be offset by the abolishment of an existing position and requests for upgrading without identification of funding support must be submitted within time limits established by the Comptroller (CAST) for Budget Change Proposals.

c. CASS will review the request for classification and grade propriety, obtain Department of Personnel Administration approval if required and forward the request thru CAST-SB for certification of fund availability. After receipt of approval from the Deputy Adjutant General, Resources Management Division, CAST-SB will obtain necessary Department of Finance approval, if required.

d. Upon receipt of necessary approvals, CASS will advise the requesting official who may then initiate action to fill the position in accordance with paragraph 5.

**5. FILLING POSITIONS.** a. State Civil Service positions will be filled in accordance with rules established by the State Personnel Board and Department of Personnel Administration (DPA). Normally eligible candidates to fill positions are obtained from the following sources:

(1) State Personnel Board Certification of Eligibles - a listing of individuals who have been examined, certified qualified and ranked by the State Personnel Board according to examination results.

(2) SROA Lists - State Restriction of Appointments lists are prepared by the State Personnel Board and become a part of the regular Certificate of Eligibles. The list consists of all classes included in anticipated layoffs, all classes in primary demotion patterns and other classes that are closely related to these classes. Eligibles on an SROA list have priority over both promotional and open certification lists.

(3) Lateral transfer without examination of current employees of the same or related class as that of the vacant position. Applicants may be from the Military Department or another State agency. Applications are normally solicited by means of vacancy announcements distributed by CASS to the various state personnel offices and California National Guard activities.

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(4) Reinstatement of former State employees who served in the same or higher class as the vacancy, who meet the qualifications for the position. Applications are usually received in response to vacancy announcements or from applicants who have submitted general applications to the Department requesting consideration for future vacancies.

(5) Appointments of qualified applicants whose names are obtained from local State of California Employment Development Department offices, minority group associations, or the appointment of lower graded State employees when there are no applicants available from the sources identified above. Prior State Personnel Board approval is required for these appointments and such approval is given only when there are no interested candidates on a Certification of Eligibles. Appointments are made as Temporary Authority (TAU) appointments and appointed individuals will be required to take an examination and be among the top three ranks on the Certification of Eligibles within nine months of appointment in order to obtain permanent status. A probationary period is still required when individuals are appointed to permanent status from TAU.

**h. Procedures.**

(1) Supervisors desiring to fill State Civil Service positions will complete the Employee Procurement Request OTAG Form 900-22, Appendix A and forward one copy to CASS. A minimum of 30 days processing time should be considered for filling any permanent position.

(2) CASS will verify the vacancy and take the action requested on the OTAG Form 900-22. TAU authority will only be requested when there is no existing Certification of Eligibles available from the State Personnel Board. If a Certification of Eligibles is requested, CASS will provide requesting supervisors the names and addresses of individuals from the Certification of Eligibles who have indicated interest in the position. Upon receipt of the list from CASS supervisors will:

(a) Interview applicants if possible. Phone interviews are encouraged when personal interviews cannot be conducted.

(b) Not request any applicant to waive their entitlement to consideration.

(c) Obtain written statements from those applicants who voluntarily waive consideration and submit to CASS.

(d) Not direct or allow any applicant to report to work until appointment approval has been received from CASS.

(e) Insure adherence to the Military Department Affirmative Action Plan.

(f) Select from the top three names or from the top three ranks of scores on the list after any voluntary waivers have been obtained.

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### SECTION III - PERSONNEL ACTIONS

#### 6. APPOINTMENTS. a. Types of appointments.

(1) Permanent (full or part time) - from sources identified in paragraph 5a (1) (2) (3) and (4), to permanent budgeted positions. A minimum six month probationary period is required.

(2) Permanent Intermittent - used to fill a position on an intermittent or irregular basis. Source of applicants is same as for permanent appointments.

(3) Limited Term - shall not exceed two days less than six months; used to fill seasonal or temporary positions or to replace a permanent employee on extended leave of absence.

(4) Temporary Authorization (TAU) used when no employment list or other eligible applicants are available. TAU appointments require State Personnel Board approval of the individual selected. TAU appointments to a permanent position are made for a nine month period pending examination and certification by the State Personnel Board. The employee must qualify in one of the top three ranks on the Certificate of Eligibles issued by the State Personnel Board or the Military Department Delegated Certification Section, in order to be appointed to a permanent position.

(5) Emergency - authorized for short term situations. Limited to 60 working days in any 12 consecutive calendar months. Appointee is not required to meet the minimum qualifications for the class appointed but must be capable of adequately performing the duties of the position. All emergency appointments are on an hourly salary rate. Final determination of qualifications for emergency appointments rests with the Director, State Personnel Programs.

(6) Retired Annuitant - a retired person may work without reinstatement from retirement (or loss or interruption of benefits) for 90 working days or 720 hours in any calendar year.

(7) Seasonal and Youth Aids - Seasonal appointments are limited to Seasonal Clerk and Maintenance Aids. Applicants for seasonal positions will be obtained by the local manager contacting the Employment Development Department for AFDC eligibles. Youth Aid applicants are to be obtained from local newspaper advertisements placed by managers. The advertisement will include the title of the position and a description of duties. Any student may be appointed to a youth aid position. Students 16 years of age and under must have a work permit issued by the Administrative Office of the school they attend.

#### b. Appointment Procedures.

(1) When an applicant has been selected for appointment from any of the sources outlined in paragraph 5 above, supervisors will submit a Health Questionnaire, State Form 610, Appendix C, and an Authorization for the Release of Medical Information, SPB Form 933, Appendix D, in an envelope marked "Confidential/Medical Information" to CASS.

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(a) The Health Questionnaire, Appendix C, must be completed by the applicant and by an examining physician for all new and reinstatement appointments other than to clerical positions. The State will pay up to a maximum of \$41.36 for pre-employment physical examinations. The physician's invoice may be submitted with the applicant packet or directly to this headquarters, ATTN: CAST-SC; or if paid by the employee, reimbursement for medical examination expenses must be claimed on State Form 262, Travel Expense Claim, Appendix E, with receipt attached. The Medical Questionnaire portion of the State Form 610 must be completed for all appointments not requiring a physical examination.

(2) Upon notification from CASS of medical approval, Supervisors will submit OTAG Form 900-18, State Civil Service Personnel Action Request, Appendix F, with the following additional forms:

- (a) State Form 686, Employee Action Request, Appendix G.
- (b) SPB Form 300-1070, State Employee Race/Ethnicity Questionnaire Appendix H.
- (c) State Form 678, Application for Examination, Appendix I.
- (d) State Form 689, Oath of Allegiance, Appendix J.
- (e) State Form 243, Designation of Person Authorized to Receive Warrants, Appendix K.
- (f) HBD Form 12, Health Benefits Plan Enrollment Form, Appendix L.
- (g) State Form 692, Dental Enrollment Plan Authorization, Appendix M.
- (h) State Form 700, Vision Plan Enrollment Authorization, Appendix N.
- (i) OTAG Form 900-23, Employee Orientation, Appendix O.
- (j) OTAG Form 900-25, Military Service Information, Appendix P.
- (k) OTAG Form 900-17, Federal Privacy Act Statement, Appendix Q.
- (l) OTAG Form 900-24, Incompatible Activities Statement, Appendix R.
- (m) OTAG Form 900-7, Emergency Information Form, Appendix S.
- (n) State Form T-SPB 131, State Employee Disability Questionnaire, Appendix T.
- (o) State Form PERS-ADM 42, Acknowledgement of Receipt of Retirement Information, Appendix U.

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(3) The HBD Form 12, Appendix L, is required for appointments of six months or more and may be submitted up to 60 days after the effective date of appointment. Applicants should be reminded the coverage becomes effective the first day of the month following the submission of HBD Form 12. Submission of the HBD Form 12 is required even when an individual declines coverage.

(4) The STD Form 692, Dental Plan Enrollment Authorization and Privacy Notice, Appendix M, is required for appointment of six months or more and may be submitted up to 60 days after the effective date of appointment. Applicants should be reminded that the coverage becomes effective the first day of the month following the submission of STD Form 692 if processed by CASS and received at the State Controller's Office prior to the 10th of the month. If the STD Form 692 is processed after the 10th of the month, coverage will be delayed by one month. Submission of the STD Form 692 is required even when an individual declines coverage.

(5) The STD Form 700, Vision Plan Enrollment Authorization, Appendix N, is required for appointment of six months or more and may be submitted up to 60 days after the effective date of appointment. Applicants should be reminded that the coverage becomes effective the first day of the month following the submission of STD Form 700 if processed by CASS and received at the State Controller's Office prior to the 10th of each month. If the STD Form 700 is processed after the 10th of the month, coverage will be delayed by one month. Submission of the STD Form 700 is required even when an individual declines coverage.

(6) When positions require a National Agency Check/Security Clearance, Supervisors will be forwarded specific documents and instructions by CAAS.

**7. REASSIGNMENTS.** Requests for reassignments including promotions within the Military Department will be accomplished by submission of the OTAG Form 900-22, Appendix B, Employee Procurement Request. CASS will advise supervisors of any additional administrative actions required.

**8. SEPARATIONS. a. Resignation Without Fault.**

(1) **Voluntary Separation From State Service.** Employees voluntarily separating from State Service must complete STD Form 687, Separation/ Disposition of Retirement Contributions, Appendix V. Employees failing to sign the separation document, must write to the Public Employees' Retirement System and request a refund of retirement contributions unless they wish to leave contributions on account.

(2) **Automatic Resignation of Intermittent Employees.** An intermittent employee who waives three requests to report for work may be automatically separated, provided that no waiver shall be counted if the employee was unable to come to work due to illness or other good reason acceptable to the Department. An intermittent employee whose non-work period extends more than one year shall be paid a lump sum payment for all accumulated vacation and overtime credits as though separated from state service and shall lose all accumulated sick leave and seniority credits.

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(3) **Failing to Meet Employment Conditions.** Employees who fail to meet the conditions of employment such as a requirement for a special license will be automatically separated within 30 days.

**b. Resignation With Fault.**

(1) **AWOL - Absent without leave for five or more consecutive days constitutes an automatic resignation with fault.**

(2) **AWOL - Failure to return from leave of absence within five consecutive days is an automatic resignation with fault.**

**c. Separation of TAU, LIMITED-TERM, Emergency and Retired Annuitant Employees.** Employees receiving TAU, LT, emergency appointments and retired annuitant appointments can be separated by the department at any time without a STD Form 687. No formal resignation is required. Supervisors no longer needing the services of TAU, LT, emergency or retired annuitant employees or who are dissatisfied with an employee's performance may request separation by advising CASS in writing and submitting a STD Form 634, if applicable, without delay. Employees who were employed by the Military Department or another State Agency immediately preceding their TAU or LT appointment may be returned to their former position.

**d. Involuntary Separations.** Involuntary separations not for cause either because of lack of funds or work or because of position abolishment will be initiated by CASS and processed in accordance with State law.

**e. Punitive Separations.** See Part VI.

**f. Death.** The death of an employee will be reported to CASS immediately. The date and time of death, work or leave status and the place of death will be reported as soon as the information is available. A final absence and additional time worked report, State Form 634, Appendix X, must be submitted without delay to CASS. A death certificate is required by Public Employees's Retirement System (PERS) before any benefits are considered.

**g. Employee Clearance.** Supervisors must complete an Employee Clearance Form, OTAG Form 900-28, Appendix W, for all separating employees and submit to CASS.

**9. SALARY ADJUSTMENTS. a. Special In-grade Salary Adjustment (SISA).** An employee who has met the efficiency standards required for his/her position and is appointed to a class with a maximum salary of \$1392, or lower, (Range A is used to determine the maximum), may receive a special in-grade salary adjustment to the second step. Normally, the increase is effective on the first monthly pay period following completion of six months of qualifying service.

**b. Merit Salary Adjustment (MSA).** An employee who has met the efficiency standards required for his/her position, may receive a merit salary adjustment to the next step in the salary range. An adjustment will normally be granted 12 months after the employee's appointment or 12 months after the last salary adjustment was made, whichever is longer.

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c. Approval or denial of special In-grade and Merit Salary Adjustments require the supervisor's written certification of appropriate performance. The certificate must be completed to indicate approval or disapproval of the SISA or MSA and returned to CASS prior to the effective date of the increase. However, failure to submit a certificate denying a SISA or MSA will result in automatic approval and payment of the increase. CASS will forward appropriate certification to supervisors prior to the authorized effective date of an MSA. Pay increases denied by a supervisor may be reconsidered after three months if the employee's performance justifies an increase at a later date.

#### SECTION IV - BENEFITS

10. **RETIREMENT.** a. State Civil Service employees appointed for periods in excess of six months are entitled to Employee Retirement Benefits and must choose between two retirement plans, known as the "First Tier" and the "Second Tier", with the State Public Employees' Retirement System (PERS).

b. Under the First Tier Plan, employee and the State both make contributions toward employee's retirement to PERS. The contribution for miscellaneous members is 5%, safety retirement members contribute 8%. PERS is a retirement program which is coordinated with Social Security (OASDI) and appropriate deductions for OASDI are made in conjunction with PERS deductions.

c. Under the Second-Tier Plan, employees do not make retirement contributions and benefits are entirely funded by the State. Annuities upon retirement are approximately one half that provided under the First-Tier Plan. Appropriate deductions are still withheld for OASDI.

d. An employee designated as managerial, supervisory, confidential or otherwise excluded from collective bargaining, or an employee in a bargaining unit that has selected the Second-Tier Plan will initially be automatically enrolled in the Second-Tier Plan.

e. Employees have 120 days from appointment date to elect to be covered by the First-Tier Plan, and must submit PERS-ADM 42C, Appendix X, to CASS.

f. Employees who remain in the Second-Tier Plan, by election or by making no election, may not change that decision in the future. Detailed information is available in the Two-Tier Retirement Information Election Package provided each new employee.

g. Individuals should notify CASS six months prior to their intended retirement date and should contact the local PERS office for a retirement counseling appointment.

11. **HEALTH INSURANCE.** a. All employees eligible for PERS benefits are also eligible for health insurance benefits for which the State contributes a major share of the premium. There are many medical and hospitalization plans available.

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These plans are explained in the annual booklet published by PERS and titled "BASIC HEALTH PLANS". This booklet is provided all new employees. Individual plan booklets are also provided by CASS to employees upon request. For employees in Unit 13, - The Stationary Engineer Local 39, Health and Welfare Trust Fund is responsible for the enrollment of all eligible employees and annuitants. The State employer makes a monthly payment into the Trust Fund for each employee and annuitant for both health and dental benefits.

b. **Dental Insurance.** All employees who are eligible for PERS membership are also eligible for Dental Insurance benefits. The State will make contributions for dental services premiums to the appropriate carrier. Contributions will vary according to plan costs, family size and other relevant factors. Dental Plan information is provided each new employee by CASS.

c. **Vision Insurance.** All active employees who are eligible for PERS membership are also eligible for vision insurance benefits. The State will make contributions for vision service premiums to the appropriate carrier. Vision Plan information is provided each new employee by CASS.

d. **Enrollment Periods.** Employees may only register for health, dental and vision insurance during the first 60 days of their appointment or transfer, or during the annual open season period. Open season periods will be announced by CASS.

e. **Deferred Compensation.** The Internal Revenue Service has approved a plan for State of California employees whereby they may contribute to a Deferred Compensation retirement plan and have that amount of the monthly contribution considered non-taxable income. Taxes on Deferred Compensation contributions are paid on the full amount (contribution plus investment earnings) when the funds are withdrawn. Funds are available for withdrawal only upon retirement or leaving the State service. Contributions to the Deferred Compensation program are limited to 25% of an individual's salary or \$625.00 per month, whichever is smaller. Interested employees can obtain additional information on the program from CASS.

12. **ADDITIONAL INSURANCE PROGRAMS.** Various employee organizations provide additional insurance programs to include life insurance, additional medical insurance, dental insurance, income protection, auto and homeowners policies. Local employee organizations representatives may be contacted for information on these programs or CASS can be contacted to obtain the employee organization(s) representing a particular employee. Various collective bargaining units' representatives provide additional insurance programs for their members. Unit representatives may be contacted for information on these programs. CASS can be contacted to obtain the employee organization representing a particular employee.

13. **WORKER'S COMPENSATION.** a. Worker's Compensation benefits are available for employees who are injured or become ill as a result of job related incidents.

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b. Worker's Compensation benefits are administered by the State Compensation Insurance Fund (SCIF). The benefits are numerous and varied under the program but include:

- (1) Medical benefits.
- (2) Temporary disability payments.
- (3) Permanent disability payments.
- (4) Vocational rehabilitation.
- (5) Death benefits.

c. In the event of an on-the-job illness or injury the employee will:

- (1) Report work related injury to his supervisor immediately but not later than 24 hours after the incident.
- (2) Obtain first aid for minor injury and return to work.
- (3) Accept examination and treatment arranged by supervisor, if required.
- (4) Tell doctor about the cause of injury.
- (5) Return to work unless doctor advises otherwise. Leave is not charged for date of injury.
- (6) If on disability, keep supervisor informed of any change in status of condition including a return to work date, if known.
- (7) Employees must submit a STD Form 634, Absence and Additional Time Worked Report, reflecting date of injury and any dates of time lost due to injury. Employees on disability must continue to submit STD Form 634 each month.

d. In the event of an on-the-job illness or injury the supervisor will:

- (1) Accept the report of work injury and act within best judgement considering the following:
  - (a) Employee's wounds, pain, suffering and urgency for treatment.
  - (b) His mobility, physical limitation and determine the transportation need to home, doctor or emergency facility.
  - (c) Employee's need for medical service.
- (2) Assure that first aid is administered for minor injury and determine if employee is able to return to work.
- (3) Provide professional medical treatment when necessary.

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(a) Arrange for treatment by a physician (follow directions locally posted on STD Form 621).

(b) Complete Sections A, B, and C of Supervisor Injury Prevention Report, STD Form 620, for Appendix Y. (In extreme emergency, get the injured to any available doctor, hospital, etc., and follow up later with STD Form 620). Submit completed STD Form 620 to CASS no later than one day after injury or illness occurs.

(c) SCIF Form 67, Appendix Z will be prepared by CASS personnel from information on the STD Form 620. CASS will contact employee to tell him/her the available benefits after SCIF determines the injury or disease is work related. CASS does not make any determination for eligibility. State Compensation Insurance Fund will notify CASS when they reach a decision.

(4) If the injured employee does not have sufficient leave to cover time off due to an injury, he or she will be paid for actual time worked only. The employee must wait until SCIF determines eligibility before disability payments are made.

e. Employees off work due to on-the-job injury or illness who are PERS members:

(1) May elect to receive either Industrial Disability Leave (IDL) payments, or Temporary Disability (TD) payments supplemented by leave credits or Temporary Disability payments only. An Industrial Disability Benefit Information Form, Form 619, sent by CASS will assist employees in making the benefits selection.

(2) The employee has 15 days in which to notify CASS of the benefits selected by returning the Disability Benefit Selection Card, Form 618, sent to the employee with the Form 619.

(3) In order to insure accurate compensation, supervisors should assist employees in completing and filing forms. Supervisors are also responsible for promptly advising CASS when employees return to work from IDL or TD.

f. Temporary employees (non-PERS members) will receive Temporary Disability only. This benefit is paid by SCIF directly to the employee.

**14. NON-INDUSTRIAL DISABILITY INSURANCE (NDI).** a. All full-time employees who are members of PERS and who become mentally or physically disabled (including pregnancy) due to non-work related illness or injury are eligible to receive NDI benefits. NDI is a program administered by the Employment Development Department. Part-time or intermittent employees must have the equivalent of six months paid State employment during the preceding 18 months to be eligible for NDI benefits.

b. The waiting period varies according to employees employment status and/or Collective Bargaining Unit. The waiting period may be waived by EDD if employee is hospitalized.

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c. If the employee is receiving temporary disability benefits under Worker's Compensation laws, NDI will only provide benefit payments less the amount already received.

d. Employees do not accrue sick leave, vacation or service credits during the period they are on NDI leave. The employee can choose to use accrued sick leave and vacation credits according to their collective bargaining unit contract.

e. Supervisors are responsible for advising CASS to prepare a Non-Industrial Disability Insurance Form, DE 8501, Appendix AA, immediately upon being notified by the employee of the disability.

f. CASS will complete in duplicate the upper portion of DE 8501 before mailing it to the employee. It is then the employee's responsibility to complete the bottom portion of the form, RETURN DUPLICATE TO CASS, AND have his/her physician complete the reverse side and mail the form to: EMPLOYMENT DEVELOPMENT DEPARTMENT, at the address indicated on form. Employee must be on pay status at the commencement of the illness.

g. Benefits vary according to employees collective bargaining unit, and will be based on previous salary, length of employment and other criteria established by EDD.

#### SECTION V - UNEMPLOYMENT INSURANCE

15. **PURPOSE.** The following policy provides for administering and managing the Unemployment Insurance (UI) Program for state employees in the Military Department.

16. **RESPONSIBILITY.** The State Department of Employment Development (EDD) has overall responsibility for administering the UI Program for all state and private sector employees. Within the Military Department the Director of State Personnel Programs (CASS) is designated as the administrator of the Departmental Unemployment Insurance Claims Management Program. The dual responsibility of the Director of State Personnel Programs as administrator of the program is to insure employees and supervisors are informed of their rights under the Unemployment Insurance Code and to develop and maintain an internal administrative procedure for monitoring the reviewing UI Claims. Supervisors have responsibility for following the Claims Management Program and to assist in reducing the departments unemployment.

17. **UNEMPLOYMENT BENEFITS AND ELIGIBILITY.** a. UI benefits are available to former employees, to employees who are unemployed temporarily (including intermittent employees) and to employees whose work during a given week has been reduced. Such employees may be entitled to part of full UI benefits provided they are:

- (1) Unemployed or working part-time through no fault of their own.
- (2) Able to and available for work.

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- (3) Actively seeking work as directed by EDD.
- (4) Meeting all requirements of the law.
- (5) Complying with regulations in regard to filing claims.

b. A claimant may be disqualified for unemployment insurance under the following conditions:

- (1) Left most recent work without good cause.
- (2) Discharged for misconduct connected with his or her most recent work.
- (3) Left work because of a trade dispute.
- (4) Not available for work, not able to work, or not seeking work.
- (5) Refused to accept suitable employment when offered.
- (6) Made a false statement or withheld a material fact, with full knowledge of such act, in order to obtain unemployment insurance benefits.

c. The weekly benefit amount to which a claimant may be entitled is based on his/her wages during a previous one year period known as the "base period". The claimant's employer(s) for that period is referred to as the base period employer(s). The benefits paid to a claimant are chargeable against a base period employer (in this case, the department). If there are two or more base period employers, the charges are prorated on the basis of the percentage of the total base period wages each employer paid. The base period for a claimant is determined as follows:

<u>FOR NEW CLAIMS BEGINNING IN:</u>	<u>THE BASE PERIOD IS:</u>
February, March or April	Year ended previous September 30
May, June, or July	Year ended previous December 31
August, September, or October	Year ended previous March 31
November, December, or January	Year ended previous June 30

A claimant is entitled to the lesser of 26 weeks of his/her weekly benefit amount, or one half his/her base period earnings. The maximum duration payable under normal circumstances is 26 weeks. An additional 13 weeks of extended benefits are payable during periods of high unemployment if Congress so authorizes an extension. The benefit year is the 52 week period which begins on the date when the individual's valid new claim begins. A claimant, after establishing a benefit year, who interrupts his/her claim may again claim benefits by filing an additional or reopened claim during the benefit year.

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**18. EMPLOYEE CLAIMS PROCEDURES.** a. Claims are filed with EDD by eligible employees in accordance with EDD rules.

(1) Claimant files for unemployment insurance benefits in person at an EDD field office. A written statement of the reason for unemployment is taken by the claims examiner and a copy of the claimant-completed initial claim notification (Form DE1101C) is mailed to the claimant's last employer to verify the facts surrounding the claimant's separation. The claim notice is sent to the address provided by the claimant which should be OTAG, ATTN: CASS.

(2) After completing a one-week waiting period, the claimant reports in person to claim payment for the first compensable week. During this time, the claimant's last employer may have responded to the initial claim notice (DE1101C) within the prescribed 10 days and challenged the claimant's eligibility if the separation was due to anything other than lack of work. If the last employer did respond with information, the claimant is scheduled for a determination interview. The field office adjudicator will prepare a written record of the interview, where an employer representative may also be present. If the employer challenged the claimant's eligibility within the 10 day period, the employer will receive a written notice of determination (Form DE 1080). If employer does not challenge the claimant's eligibility within the initial 10 day time period, the claimant will be interviewed about job prospects and his/her attempts to find work.

(3) If the claimant is found eligible for benefits as a result of the interview addressed above, the claimant receives payment and enters into a regular continued claim status. During this time, the claimant mails a self-completed form to the field office very two weeks to certify entitlement for biweekly benefits. If the answers on the form raise no eligibility issues, and if the employer has not challenged the claimant's eligibility during this time, the field office interviewer authorizes payment biweekly, and a check is mailed to the claimant. If during this time the employer has challenged the claimant's eligibility and the determination has been issued, either the claimant or the employer may want to appeal the determination of eligibility.

(4) The claimant continues to receive checks biweekly upon certification until a periodic eligibility interview is scheduled. At this interview, the claimant reports in person and completes a form recording his/her efforts to find work. The field office interviewer will review this form and any other claim documents on file, and question the claimant on specific work-seeking efforts. The claimant, if found still eligible, continues on a regular continuous claim status until the next periodic eligibility interview or until the claimant exhausts his/her 26 weeks of benefits.

b. Since the state must pay the cost of full or partial unemployment insurance benefits paid to employees and former employees, the department must reimburse the EDD for funds paid under the above procedures.

**19. SUPERVISOR/STATE PERSONNEL PROGRAMS DIRECTORATE PROCEDURES.** a. A supervisor, whenever possible, should conduct an interview with a departing

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employee to either inform the employee why they are being terminated or to determine why the employees are leaving. At the time of the interview or sometime prior to employees departures the employee should be provided and requested to sign a STD Form 600 (Appendix BB), Unemployment Insurance Record. The original copy of the form should be forwarded to CASS and one copy provided the employee. It is also suggested that supervisors retain one copy of the form. Additionally STD Form 660 (APPENDIX CC), Unemployment Compensation Notice should be provided to the employee. The STD Form 660 if not preprinted should indicate Military Department, ATTN: CASS, P.O. Box 214405, Sacramento, CA 95821 in the address box for state agency address.

b. The DE 1101C (UI Claim) will be the initial notification to the department that a claim has been filed, and the EDD field office sends these notices to the address provided by the claimant. Ideally, if the employee is given and refers the STD Form 660 with the address of the Directorate of State Personnel Programs stamped in the box, the claim form will go to CASS, and worksite supervisor will not receive the notice. If the claim notice is sent to the worksite, time may not permit sending the notice to CASS, and the notice will have to be completed by the supervisor or designated representative at the worksite. The DE 1101C must be returned to the EDD office of origin within 10 calendar days of the mailing date on the form if there is any disqualifying information to report. If this information is not provided to EDD within the 10 day limit, the Military Department cannot prevent the claimant from initially receiving benefits. Disqualifying information to report back to EDD on the DE 1101C would include, but be limited to:

- (1) Employee terminated for misconduct,
- (2) Employee terminated for medical reasons,
- (3) Employee voluntarily resigned,
- (4) Employee is not able to work,
- (5) Employee is not seeking work as directed, or
- (6) Employee willfully made a false statement or withheld a fact in order to obtain benefits.

c. If a challenge to benefits has been made by the department, the EDD field office will review the circumstances, interview the employee and in some cases the employer and will issue a determination on DE Form 1080; either party not agreeing with the determination may appeal to EDD.

20. **APPEALS.** a. Appeals to EDD will be filed only by the Director, State Personnel Programs based on facts available through records or directly from supervisors.

b. Appeals are submitted by letter or on DE Form 1000 in accordance with the instructions on DE Form 1080 and must be submitted to the field office within 20 days of the mailing date of the DE Form 1080.

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c. Date, time and location of an appeal hearing, will be established by the designated Administrative Law Judge who will issue a decision. If the decision is against the department, the department may further appeal to the California Unemployment Insurance Appeals Board. Such an appeal must be filed within 20 days of the mailing of the Administrative Law Judges decision. Any decision by the appeals board may not be administratively appealed further.

#### SECTION VI - LEAVE/HOLIDAYS

21. **VACATION LEAVE.** a. State Civil Service employees other than those designated as managerial, confidential, supervisory and exempt employees from collective bargaining are entitled to annual leave as shown:

- (1) 1 month to 3 years      7 hours per month (84 hours per year)
- (2) 37 months to 10 years    10 hours per month (120 hours per year)
- (3) 121 months to 15 years   12 hours per month (144 hours per year)
- (4) 181 months to 20 years   13 hours per month (156 hours per year)
- (5) 241 months and over     14 hours per month (168 hours per year)

b. The annual leave accrual rate for managerial, confidential, supervisory and exempt employees excluded from collective bargaining is as shown:

- (1) 1 month to 3 years      7 hours per month (84 hours per year)
- (2) 37 months to 10 years    11 hours per month (132 hours per year)
- (3) 121 months to 15 years   13 hours per month (156 hours per year)
- (4) 181 months to 20 years   14 hours per month (168 hours per year)
- (5) 241 months and over     15 hours per month (180 hours per year)

c. The maximum allowable carryover of vacation per calendar year is 320 hours for all employees except Unit 7 and 9 employees who are allowed 360 hours per calendar year. Non-represented employees may carry over 400 hours per calendar year.

d. Vacation cannot be used before it is earned or in units of less than 1/8 of a day.

22. **SICK LEAVE.** a. Sick leave means the necessary absence from duty of an employees because of:

- (1) Illness or injury including illness or injury related to pregnancy.

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(2) Exposure to a contagious disease which is determined by a physician to require absence from work.

(3) Dental, Eye and other physical or medical examinations or treatment by a licensed practitioner.

(4) Absence from duty for attendance upon the employee's ill or injured mother, father husband, wife, son, daughter, brother or sister or any person residing in the immediate household.

(5) Death of person related by blood, adoption, marriage or of any person residing in the immediate household of the employee. Employees must provide substantiation to support the request for bereavement leave.

b. On the first day of the pay period following completion of 11 or more working days, employees shall earn credit for sick leave according to their Collective Bargaining Unit.

c. Intermittent employees shall earn sick leave credit according to their collective bargaining unit, and completion of 160 hours of paid employment.

d. Part-time employees shall be allowed sick leave on a pro rata basis, the fractional part of one day of credit for sick leave with pay.

e. Appropriate supervisors shall approve sick leave only after having ascertained the absence is for an authorized reason and may require the employee to submit substantiating evidence including, but not limited to, a physician's certification. If the supervisor does not consider the evidence adequate, the request for sick leave shall be disapproved.

f. Section 8, Reason for Absence, of the STD Form 634 shall be completed in enough detail to leave no doubt that the employee was too ill to report for duty. The reasons for illness or injury will be reviewed by CASS staff. If the reasons given are not adequate, the STD Form 634 shall be returned for further information.

g. Unless an employee used more than two days of sick leave, except where an employee has a demonstrable pattern of sick leave abuse, he or she shall not be required to provide a doctor's verification.

h. Sick leave may be used for on-the-job injuries; however, supervisors of employees absent because of on-the-job injuries should contact CASS to determine the most advantageous status to report an injured employee.

**23. BEREAVEMENT LEAVE.** a. Bereavement Leave for a permanent employee is authorized in accordance with employee's Bargaining Unit contract, or in accordance with Department of Personnel Administration for excluded employees. An employee will notify his/her supervisor within 24 hours and will provide substantiation to support the request. Authorized Bereavement Leave is not charged to the employee's leave credits. All union contracts provide for a minimum of three days Bereavement Leave.

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b. A notice from mortuary or newspaper must be attached to the STD Form 634 for usage of Bereavement Leave.

24. **MILITARY LEAVE.** a. Military leave is authorized to State Civil Service personnel in accordance with the military leave provisions of the Government Code. Normally, entitlement begins when an individual has completed one year of continuous service in a State paid position, but the one year service requirement may be a combination of service in a State paid position and recognized Federal military service through 14 September 1976. For the purpose of military leave entitlement, recognized military service is defined as full time service in the US Armed Forces or service as a member of the California National Guard during a State military emergency as proclaimed by the Governor.

b. Individuals who qualify for military leave are authorized a maximum of 30 calendar days military leave each fiscal year (1 July - 30 June). With the exception of Inactive Duty Training, each day for which federal military pay is received will be charged to military leave and then to other leave when the maximum military leave has been exceeded. Supporting orders must be submitted with attendance reports indicating use of military leave. Unused military leave cannot be carried forward to the next fiscal year.

c. State Civil Service personnel who qualify for military leave are entitled to full payment of salary during the first 30 days of military duty each fiscal year.

d. If an individual does not qualify for military leave, accrued ordinary leave or leave without pay must be used to cover the absence on federal military duty.

e. Indefinite military leave is a military leave granted to an individual ordered to federal active duty in any recognized military service by draft, enlistment or appointment. The first 30 days of such duty will be in a paid military leave status less any military leave previously used during the fiscal year.

f. Upon termination of Federal active military service, State Civil Service personnel on indefinite military leave have the right to reinstatement to their former position or a comparable vacant position of like seniority and pay. Application for reinstatement must be made within 90 days of release from active duty.

25. **ADMINISTRATIVE LEAVE.** Employees who are participating in a State Civil Service examination, or a promotional interview are authorized Administrative Leave without loss of compensation if the examination or interview has been scheduled during his/her normal work hours, and the employee has provided reasonable notice to his/her supervisor. Reasonable Administrative Leave shall be approved with consideration for travel time to and from required location. A copy of the examination notice or promotional interview notice must be attached to the STD Form 634. Employees seeking a lateral transfer to another State agency are not permitted Administrative Leave.

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26. **JURY DUTY.** a. Employees are authorized time off without loss of compensation when ordered to jury duty. The payment received from the court for jury duty must be remitted to CAST-ACS when an employee is on paid jury duty leave.

b. A Court Subpoenaed witness may be absent with pay except as follows:

- (1) The employee is a witness as a party to a suit;
- (2) Employee is an expert witness but not serving in the interest of the State;
- (3) The employee receives Court fees in excess of his regular earnings.

c. If an employee elects to use accrued vacation leave, compensating time off, or leave without pay the employee is not required to remit jury duty fees.

27. **PERSONAL HOLIDAY.** Permanent State Civil Service personnel are authorized to take a personal holiday consisting of one day off without charge to leave during the fiscal year. The Personal Holiday may not be carried forward from one fiscal year to the next. Limited Term and TAU employees are not entitled to a personal holiday. Employees on initial probation are not entitled to a personal holiday until after they complete the probation period or six months service, whichever comes first.

28. **HOLIDAYS.** a. Holidays are days in which employees are excused from work with pay without charge to leave.

b. An employee may be excused from work with pay on the following days:

January 1 - New Year's Day

Third Monday in January - Martin Luther King's Birthday

February 12 - Lincoln's Birthday

Third Monday in February - Washington's Birthday

Last Monday in May - Memorial Day

July 4 - Independence Day

First Monday in September - Labor Day

Second Monday in October - Columbus Day

November 11 - Veteran's Day (10th if 11th is Saturday)

Thanksgiving Day

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Friday after Thanksgiving Day

December 25 - Christmas Day

Any day designated by the Governor as a holiday

c. If a holiday falls on a Sunday, the following Monday will be observed as a holiday.

d. Except for firefighters, who have special overtime provisions, time worked on a holiday is considered and credited in the same manner as other overtime worked.

29. **LEAVE WITHOUT PAY.** Leave without pay will be granted to State Civil Service personnel under exceptional circumstances when no other leave is available. When granted, supervisors will call CASS immediately to report leave without pay. Attendance at a service school after military and ordinary leave have been totally utilized is considered an "exceptional circumstance". Neither ordinary nor military leave will accrue while an individual is in a leave without pay status. Supervisors should consult CASS pertaining to temporary replacements, employee rights, benefits coverage and related matters prior to authorizing employees LWOP which exceeds 30 days.

30. **ABSENCE WITHOUT LEAVE.** a. It is considered absence without leave when an employee:

- (1) Does not report to work and does not notify the supervisor.
- (2) Takes time off when request for leave has been disapproved.
- (3) Does not return to work from a leave of absence and does not submit a resignation.

b. An employee will not receive pay for the period of absence without leave and must be separated after five consecutive working days of absence without leave.

c. An employee is not considered absent without leave if the supervisor is notified, unless the supervisor has clearly stated that the reason for absence is unacceptable and that the absence is not approved. Supervisors will notify CASS immediately when absence without leave occurs.

## SECTION VII - DISCIPLINE AND PUNITIVE ACTION

31. **INFORMAL DISCIPLINE.** Informal disciplinary actions are normally admonitions or warnings and are usually the first step in the disciplinary ladder. An oral admonition is the least formal and severe action and should be administered by supervisors during scheduled counselling or interviewing or as an on-the-spot

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corrective action. When oral admonitions are used, supervisors should clearly advise the employee of the infraction or unauthorized conduct and state what corrective action must be taken. Employees are entitled to a representative during any discussion with management that may lead to disciplinary action. Supervisors may record admonitions when they desire and should do so in cases where past admonitions have not been successful or it appears more stringent disciplinary action may be required.

**32. FORMAL DISCIPLINE (Punitive Actions).** a. **Definition.** Formal action initiated by management for just cause to correct inappropriate employee behavior, including dismissal, demotion, suspension, or other disciplinary action. The State of California Government Code defines causes for discipline as follows:

- (1) Fraud in securing appointment.
- (2) Incompetency.
- (3) Inefficiency.
- (4) Inexcusable neglect of duty.
- (5) Insubordination.
- (6) Dishonesty.
- (7) Drunkenness on duty.
- (8) Intemperance.
- (9) Addiction to the use of narcotics or habit-forming drugs.
- (10) Inexcusable absence without leave.
- (11) Conviction of a felony or conviction of a misdemeanor involving moral turpitude. A plea or verdict of guilty, or a conviction following a plea of nolo contendere, to a charge of a felony or any offense involving moral turpitude is deemed to be a conviction within the meaning of this section.
- (12) Immorality.
- (13) Discourteous treatment of the public or other employees.
- (14) Improper political activity.
- (15) Willful disobedience.
- (16) Misuse of State property.
- (17) Violation of a State Personnel Board rule.

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(18) Violation of the prohibitions of incompatible activities.

(19) Refusal to take and subscribe any oath or affirmation which is required by law in connection with his employment.

(20) Other failure of good behavior either during or outside of duty hours which is of such a nature that it causes discredit to his agency or his employment.

(21) Disloyalty to the United States during war time as determined by the U.S. Congress.

**b. Written Reprimands.**

(1) Written reprimands are formal punitive actions taken to correct conduct, work habits or attitude.

(2) A written reprimand is used where prior admonitions have been unsuccessful in correcting a problem or for more serious infractions where an admonition would be insufficient.

(3) A written reprimand should only be issued after a supervisor has gathered all the facts, interviewed the employee and listened to any explanation, and has determined that such action is warranted. Supervisors should coordinate with CASS prior to issuing a letter of reprimand.

(4) The following individuals are authorized to issue letters of reprimand to State Civil Service employees:

- (a) AG.
- (b) Asst AG.
- (c) DAG Army Div/DAG Air Div/DAG Resource Mgmt Div.
- (d) Asst DAG Army Div/Chief of Staff Air Div/Asst DAG, Resource Mgmt Div.
- (e) OTAG Directors.
- (f) Commanders, Camp Roberts, Los Alamitos and Camp San Luis Obispo.
- (g) ANG Station Commanders and Base Civil Engineers.
- (h) Director, California Impact.

(5) The content of a letter of reprimand will include the following:

- (a) A description of the offense in detail.
- (b) A statement that the reprimand is an official disciplinary action and will become a part of the individual's personnel record.

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- (c) A statement of previous like offenses, if appropriate.
  - (d) Information on what corrective action is required.
  - (e) A statement that additional infractions will result in more serious disciplinary action.
  - (f) Information that the individual may respond in person or in writing if he/she desires.
- (6) The letter of reprimand should be given to the individual in person, if possible, and a receipted copy (signed by the individual acknowledging receipt) obtained. The receipted copy and one additional copy will be forwarded to CASS.
- (7) The letter of reprimand will advise the employee of the right to appeal to the Adjutant General within five days or the State Personnel Board within 15 days of the receipt of the letter.

**c. Suspension/Termination/Demotions.**

(1) When more severe disciplinary action is required, the employee will continue working or is put on Administrative Leave if approved by the Director, State Personnel Programs. The supervisor must submit requests through channels to CASS for preparation of required documents. Requests must contain all the available information pertaining to the offense. As a minimum, the request must contain:

- (a) Nature of the offense and rule, law or regulation violated.
- (b) Time, date, place of offense.
- (c) Witnesses names and sworn statements where possible.
- (d) Information on past like offenses.
- (e) Action Requested (Suspension or Separation).

(2) Punitive suspensions/terminations and demotions are all subject to review and reversal by an appeal board. Additionally, an employee and his/her representative have the right to examine all documents, witnesses or other evidence pertaining to the action; it is therefore absolutely essential that facts and evidence be carefully gathered, reviewed and preserved when taking these actions. Individuals may request a Departmental hearing (called a Skelly Hearing) prior to the effective date of the action. A representative designated by the Adjutant General will conduct a hearing, review documents and evidence, hear testimony and, based on the facts provided, make a recommendation to the Adjutant General who may uphold the action, modify the punishment or dismiss the action. The employee also has the right to appeal formal disciplinary action to the

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State Personnel Board within 15 days of the effective date of the action and may request a hearing before the Board. In each appeal the burden of proof is with the initiating supervisor.

#### SECTION VIII - CODE OF ETHICAL STANDARDS

33. State Civil Service employees are subject to the Governor's Code of Ethical Standards, and the following subjects are considered to be inconsistent, incompatible, or in conflict with the acceptable conduct:

a. Providing confidential information to persons to whom issuance of such information has not been authorized, or using confidential information for personal gain or advantage or for the advantage of others.

b. Soliciting or accepting, directly or indirectly, any money, loan, employment, business, benefit or other thing of value (in addition to salary paid by the State) from anyone from whom it might be inferred as a gift to influence the State employee concerned.

c. Engaging in any employment which will prevent prompt response to a call to report to duty as required by department heads.

d. Providing, or using, the names of persons from office records for mailing lists that have not been authorized.

e. Providing, or using, unit station lists for use in circulation or advertising of articles or services.

f. Using the prestige or influence of one's office for personal gain or advantage or for the advantage of others.

g. Using State time, facilities, records, equipment or supplies for personal use or gain.

h. Receiving or accepting money, gifts or favors for services rendered during State working hours.

i. Performance of an unofficial act that may later be subject to the individual's control, inspection, review, audit or enforcement of an official State capacity.

34. Any personal knowledge of actions by employees which seem questionable, or which might be interpreted as falling within one of the above categories, should be brought to the attention of the individual's supervisor or the Adjutant General immediately.

#### SECTION IX - PAY AND ATTENDANCE REPORTING

35. **PAY PLAN.** a. The pay plan for State Civil Service employees consists of salary ranges and steps established by the Department of Personnel Administration. There is a minimum and maximum rate authorized within each range and

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ranges are designated for each class of Civil Service employment. Pay Scales have been published listing each State employee class and the appropriate range of pay for that class. State employees are paid monthly on the dates established by the Department of Personnel Administration. Pay scales applicable to positions in the Military Department will be forwarded as updated.

b. If upon receipt of the STD Form 634 by CASS, it is discovered that absences not covered by leave occurred during the month, the individual's check cannot be released, and a new payroll warrant must be issued from the State Controller's Office. This procedure will preclude payment on payday. The new payroll warrant will be issued as soon as possible after payday. To preclude this delay in pay, Supervisors must advise CASS as soon as the dates are known each month of any absences which will not be covered by paid leave.

36. **SALARY ADVANCES.** If an extreme hardship occurs to the individual due to pay being delayed, the individual may request a salary advance through his/her supervisor stating the hardship reason. Upon supervisor's approval the request is forwarded to CASS for determination by the Director, State Personnel Programs.

37. **HOURS OF WORK.** a. The normal work week for State Civil Service employees is 40 hours; 8 hours per day, 5 days per week. The Military Department's standard scheduled workweek is Saturday through Friday. CASS must be advised in any case where supervisors establish a different workweek.

b. Special work schedules for the Fire Fighter/Security Guard classifications are provided separately by the appropriate supervisors.

c. **Overtime.**

(1) When overtime work is necessary it is the policy of the State to adhere to requirements of the Federal Fair Labor Standards Act (FLSA). If the provisions of the FLSA are in conflict with the provisions of a Memorandum of Understanding (Union contract), the FLSA provisions shall be controlling unless the Memorandum of Understanding provides a greater benefit to the employee.

(2) Overtime is defined as ordered time worked in excess of the 40 hour regularly scheduled workweek. Subject to the funding restrictions authorized in 37c (6) below, supervisors may direct employees to work overtime whenever appropriate or required to accomplish the work of an activity.

(3) Overtime for employees in fire suppression classes is defined as all hours worked in excess of 212 hours in a period of twenty-eight consecutive 24 hour periods.

(4) Overtime for employees (other than those in Work Week Group 4 - usually Management employees) may be compensated either in cash or compensating time off. Employees are paid at time and one half or granted one and one half hours compensating time off for each overtime hour worked. Work Week Groups are indicated on the salary schedule issued by CASS for employees in the Military Department.

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(5) Work Week Group 4 employees are in classes and positions requiring the establishment of special provisions governing their hours of work and methods of compensation for overtime. Specific questions on Work Week Group 4 employees should be addressed to CAAS.

(6) Paid overtime must be authorized in advance. Funding approval for payment of cash overtime rests with supervisors, and Director of State Personnel Programs. Funds must have been specifically established in the State budget to support payment of overtime pay for each activity.

(7) Compensating time off, when authorized in lieu of overtime pay, must be used within 12 months of the date earned except for employees in fire suppression classes.

(8) The STD Form 634, Absence and Additional Time worked, Appendix DD, will reflect the number of overtime hours worked. In addition, a "P" will be posted with the number of hours worked for paid overtime, and a "WO" with the number of hours worked for compensating time earned, with a reason for the extra hours worked shown in the remarks section.

(9) Employees who have accrued compensating time off and have requested use of time, shall be permitted to use such time within a "reasonable period" after making the request, if such use does not unduly disrupt the operation of the agency. All use of compensating time off is at the discretion of the supervisor, who may direct the time off, if necessary.

(10) Overtime cannot accrue on the same day that leave is credited to an employee. This policy applies to sick leave, vacation, and compensating time off. When an employee is called into work while on leave status, the leave usage is reduced hour for hour with the number of hours worked not to exceed the day's total normal number of working hours (usually eight). An employee who is ordered back to work on an authorized day off will be credited with at least four hours of work time or for the number of hours actually worked, whichever is greater.

(11) Overtime credit will not be given for travel outside of regular working hours except in cases of emergency or unusually arduous travel.

(12) Employees will be credited with a minimum of four hours work time when the call back occurs after completion of the work shift. Overtime hours which are contiguous to an employees regular work shift are not call back time.

(13) In all cases involving hours of work, overtime, or compensation time, supervisors should refer to appropriate union contracts. In the event of a conflict between the contracts and this regulation, the contract language will apply.

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**d. Shift Differential.**

(1) An employee whose job requires working evening or night hours is entitled to receive a shift differential pay as a part of his regular salary.

(2) An evening shift includes 50% or more hours of work between 6:00 p.m. and midnight.

(3) A night shift includes 50% or more hours of work between midnight and 6:00 a.m.

(4) Supervisors desiring to direct evening or night shift work should coordinate with CASS prior to directing the shift work.

**e. Rest Periods.** Every employee may be granted a rest period not to exceed 15 minutes during each four hour work period. A rest period shall not be granted during the first or last hour of a work period and cannot be accumulated and used for time off.

**38. ATTENDANCE REPORTING.** a. Payroll warrants will not be released until State Form 634, Absence and Additional Time Worked Reports, Appendix DD, are received by CASS.

b. The State Form 634 will be prepared for each employee and will indicate the employee's status for each day of the pay period. The only daily coding necessary is when the employees status was other than "worked". The following specific instructions will be followed when completing the State Form 634:

(1) Date of work related injury must be shown in Section 8. If sick leave, vacation leave, compensating time off or leave without pay is used due to injury, notation must be made in Section 8.

(2) The reason for sick leave used and the reason for extra hours worked must be reported in Section 8. Forms will be returned if this section is not completed. Section 10 must be completed by the supervisor. The method of substantiation for sick leave of more than two consecutive days must be shown unless a doctor's statement is completed.

c. The State Form 634 will be submitted to arrive at CASS not later than the 28th of the month. LWOP or AWOL occurring after the submission of the Form 634 must be reported to CASS by telephone immediately. A corrected Form 634 to report all changes after the original Form 634 is submitted must be received in CASS no later than five working days after the end of the pay period being reported.

**SECTION X - PERFORMANCE EVALUATION**

**39. EVALUATION DURING PROBATION.** a. Probation ratings are required for all employees during the established probationary period. The purpose of the

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evaluation is to analyze the employee's work; determine additional training needs of the employee; determine appropriate work assignments and determine if permanent status in the position should be granted. Most probation periods are for six months; however, some positions may require a longer probation period. The length of probation is shown on the Notification of Personnel Actions (NOPA) issued to the employee.

b. Probation reports are submitted on State Form 636, Appendix EE, which are provided the supervisor within 30 days of an employee's appointment by CASS. Three reports are required, one to be submitted prior to the end of each one-third of the rating period. Normally this will be the second, fourth and sixth month. In no case may the final report be submitted later than the end of the probation period.

c. Full instructions for completing the rating forms are contained on the State Form 636. Employees must be counselled at the time each rating is rendered. If a supervisor determines to reject an employee during probation, the employee must be so informed, reviewer concurrence obtained, and the State Form 636 forwarded, with full justification for rejection, to CASS at least seven days prior to the end of the probationary period. In such cases CASS will issue a letter to the rejected employee informing him/her of the rejection and providing additional information. Individuals desiring to discuss any of their ratings with the Reviewing Officer, must be allowed to do so.

**40. ANNUAL EVALUATION.** a. The continuing appraisal of work performance provides recognition for effective performance and identifies aspects of performance requiring improvement. Supervisors shall discuss performance informally with each employee as necessary to ensure effective performance throughout the year.

b. Annual appraisals are required for each Civil Service employee. Military Department employees are rated as of 31 January each year. Within 30 days of the end of the rating period CASS will forward State Form 637, Appendix FF, to State employee supervisors for completion and return within 60 days.

c. The appraisal process includes determining performance objectives, planning for achieving the objectives and rating the employee according to various performance factors. The State Form 637 is used to record the appraisal. "Performance Objectives" should be completed by the employee, and "Plans for Achieving Objectives" should be completed by the Supervisor. The Supervisor must discuss the completed State Form 637 with the employee to include objectives and methods of performance. Both the supervisor and the employee must sign and date the completed State Form 637.

## SECTION XI - LABOR RELATIONS

41. The State Employer/Employee Relations Act (SEERA) became effective on 1 July 1978. The Act provides an employer/employee bargaining relationship

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between State government and State Civil Service Employees. There are twenty one individual bargaining units representing State employees. Nine of these units include employees in the Military Department. Those nine units are:

- |        |  |         |
|--------|--|---------|
| a. #1  | Administrative Fiscal and Staff Services | CSEA    |
| b. #4  | Office and Allied                        | CSEA    |
| c. #7  | Protective Services and Public Safety    | CAUSE   |
| d. #9  | Professional Engineers                   | PECC    |
| e. #11 | Engineering and Scientific Technicians   | CSEA    |
| f. #12 | Craft and Maintenance                    | CSEA    |
| g. #13 | Stationary Engineer                      | AFL-CIO |
| h. #14 | Printing Trades                          | CSEA    |
| i. #15 | Custodial and Services                   | CSEA    |

42. The following general guidelines are provided pertaining to employees rights and manager/supervisor relationships with union representatives. In any case, where these guidelines conflict with appropriate union contracts, the provisions of the contract will apply:

**a. Right to Representation.**

(1) Employees have the right to join organizations of their own choosing for the purpose of representation on all matters of employer-employee relations. Employees also have the right to refuse membership and represent themselves on an individual basis. Employees will not be discriminated against, granted preferential treatment, or have equitable treatment withheld because of either membership or non-membership in an employee organization.

(2) Employees shall have the right to representation or may represent themselves individually on all matters relating to employment conditions and employer-employee relations, including, but not limited to, wages, hours or other terms and conditions of employment.

(3) With respect to representation on disciplinary matters, employees are not entitled to have a representative present during routine business communications which occur between a supervisor and employee, such as performance evaluations, job audits, counseling sessions and work-related instructions. The individual's right to representation occurs when the employee reasonably believes the matter may result in disciplinary action.

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(4) Once an employee organization is recognized as the exclusive representative of an appropriate unit of employees, the recognized employee organization is the only organization that may represent employees in that unit in employment relations with the State.

b. **Access to Work Locations.** With the consent of the appropriate supervisor and within the limitations set out by these guidelines, employee organization representative may be granted reasonable access to employee work locations.

(1) The optional restrictions or limitations that management may apply to employee organizations under these guidelines should be utilized only for legitimate State purpose, such as safety, security, potential work disruption, undue State cost, etc. No optional restraints may be applied, or not be applied, on the basis of any antipathy or sympathy for or against employee organization(s) generally or in particular. The restraints imposed on employee organizations under these guidelines may be less restrictive than those placed on other groups that solicit employees in State buildings or seek to distribute or post materials, but they may not be more restrictive.

(2) Employees have no right to engage in employee organization business activities during working hours. On their own time, employees have a right to participate or refuse to participate in such employee organization activities as may be authorized on State premises.

(3) Employees' "own time" or "non-working hours" are considered to be lunch periods, regularly scheduled rest periods and time before and after work.

(4) To minimize interference with State business or established safety and security requirements, employee organization representative may not enter a work location for the purpose of organizational activity without departmental consent.

(5) Access to a work location may be denied or delayed for reasons including safety, security, workload requirements or other legitimate circumstances.

(6) Where access is denied, reasonable alternatives should be provided to allow representatives to communicate with employees (e.g., establishing employee organization meeting rooms, providing space in a cafeteria or elsewhere on the facility).

(7) Discussions between employees and their representatives about employee organization matters should generally be conducted outside the employee's immediate work area. When this is not possible, discussions in the work area may only take place if there is no disruption of State business.

c. **Solicitation of Members.**

(1) Solicitation for membership at the immediate work area can only take place during non-working time.

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(2) The handing out of petitions, employee organization authorization cards, or membership cards by an employee organization representative, with or without conversation, is solicitation. Therefore, such activity by an employee(s) on the employee's(s') "own time", among employees who are working, may be prohibited if management determines that such activity would be potentially disruptive to State business.

(3) Where management decides to limit or deny solicitation in particular work areas for reasons of safety, security, or potential disruption of work or for other legitimate reasons, it is appropriate to provide some alternate location on State premises for solicitation (as per Guideline 6).

**d. Distribution of Union Material.**

(1) With regard to the distribution and posting of employee organization material, employee organizations should be provided with a reasonable opportunity to communicate with their members and other State employees.

(2) Permission to distribute printed material, authorization cards or membership cards in work areas may be denied for reasons of safety, security or potential disruption of work or for other legitimate reasons. A reasonable alternative should be provided where work area access is denied.

(3) Employee organizations may distribute their literature in non-working areas (e.g., cafeteria, lounge areas). An employee may not use State time for such activity.

(4) Employee organizations should provide management with at least two copies of all employee organization material which is to be distributed. The copies should be sent to the Director, State Personnel Programs.

(5) The State mail service should not be utilized for distribution of employee organization mail unless there is no other method of distributing material.

**e. Bulletin Boards.**

(1) Bulletin board space should be provided for the placement of employee organization printed material.

(2) Management may designate particular bulletin boards or bulletin board areas for use by employee organizations and may develop reasonable rules governing the time and manner of such use.

(3) Employee organizations should be allowed to use designated bulletin board space to post notices of their meetings, elections, other business, recreational and social activities and information on issues relating to employee terms and conditions of employment.

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(4) Management is not required to allow material, which addresses issues other than those cited in (3) above, to be posted. Management may prohibit the posting of material which is obscene or defamatory according to current legal standards or material of a lewd or vulgar nature, or material which advocates employee action(s) that would be unlawful, in violation of regulations, or disrupt operations.

(5) In the application of the Bulletin board posting rules, it should be noted that management has an interest in protecting the reputation of its employees. Because of this interest, management should broadly interpret the standards of obscenity and defamation as applied to statements which may tend to injure the reputation of an employee.

(6) Any denial of approval of material sought to be posted or any removal of material will be subjected to usual grievance procedures. Approval procedures and grievance procedures relative to posting materials should be expedited with respect to the timeliness of material.

(7) If any employee organization material is to be removed from a bulletin board, the employee organization must be contacted as soon as possible. Every effort should be made to effect such contact prior to removal so as to afford the employee organization an opportunity to comment on management's judgment if the representative so desires.

**f. Use of State Equipment.**

(1) State equipment and supplies should not be utilized for employee organization business.

(2) Departmental reproduction systems and staff time may not be used to publish or copy material for employee organizations.

(3) State telephone facilities may be used by employee representatives for scheduling meetings with management and to discuss specific employee relations issues. Use of State telephone will not be authorized for the conduct of internal employee organization business (e.g., membership drives).

**g. Use of State Time.**

(1) No employee or State-employed employee organization representative shall conduct or participate in the internal business affairs of an employee organization during assigned working hours. These activities include: The circulation of authorization cards, solicitations for membership, campaigning in unit elections, soliciting organizational health, welfare and insurance plans, the holding of organizational demonstrations, social, political or recreational events, or the distribution of material relative to any organizational matters.

(2) Employees may, during assigned working hours, use a reasonable amount of State time to prepare and present grievances, meet with management on issues and problems, and prepare defenses for punitive actions.

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(3) With management's approval, a reasonable number of employee organization representatives, who are also employees of the State, will be allowed a reasonable amount of State time to attend (but not to prepare for) meet and confer sessions with management. The number of employees and/or representatives and the amount of time will be determined by the appropriate department manager.

(4) State time may also be used for employee representatives to travel to and from meet and confer sessions with management and to attend meetings to discuss employee grievances.

(5) Unless the meeting and/or attendees have been specifically requested by management, all travel expenses and per diem of employee organization representatives are the responsibility of the employee organization or the individual. Time spent by employee representatives on representation activities will not qualify for, or result in, overtime compensation.

**43. UNFAIR LABOR PRACTICES. a. Provisions of SEERA.** Unfair practices are those actions or inactions by employee organizations or managers which are violations of the rights guaranteed by SEERA.

b. Under provisions in SEERA, it is an unfair practice for the State to:

(1) Impose or threaten to impose reprisals on employees, to discriminate or threaten to discriminate against employees, or otherwise to interfere with, restrain, or coerce employees because of their exercise of rights under SEERA.

(2) Deny to employee organizations rights guaranteed to them by SEERA.

(3) Refuse or fail to meet and confer in good faith with a recognized employee organization.

(4) Dominate or interfere with the formation or administration of any employee organization, or contribute financial or other support to it, or in any way encourage employees to join any organization in preference to another.

(5) Refuse to participate in good faith in the mediation procedure.

d. Under provisions in SEERA, it is an unfair practice for an employee organization to:

(1) Cause or attempt to cause the State to be charged with an unfair labor practice.

(2) Impose or threaten to impose reprisals on employees, to discriminate against employees, or otherwise to interfere with, restrain, or coerce employees because of their exercise of rights guaranteed by this Chapter.

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(3) Refuse or fail to meet and confer in good faith with a State agency employer of any of the employees of which it is the recognized employee organization.

(4) Refuse to participate in good faith in the mediation procedure.

## SECTION XII - GRIEVANCE PROCEDURES

44. **GENERAL.** a. The following grievance procedures are established for State Civil Service employees of the Military Department. Employees not covered under an established collective bargaining unit or those who have a grievance not covered by the appropriate management/union contract will complete STD Form 631, Appendix GG. For rank and file employees who wish to file grievances over matters covered by their contract, STD Form 630, Appendix HH, will be used. The levels of review indicated in paragraph 36 are applicable to all grievances whether covered by a contract or not.

b. The general objectives in establishing these procedures are:

(1) To prevent undermining of employee morale by the destructive effect of unsettled grievances.

(2) To secure preventive action and develop an effective procedure for handling grievances.

(3) To formulate principles or guides for handling grievances.

c. Employees who have a problem should first try to get it settled through discussion with their immediate supervisor. If, after this discussion they do not believe the problem has been satisfactorily resolved, they may discuss it with their supervisor's supervisor. Every effort should be made to find an acceptable solution by informal means at the lowest possible level of supervision. Employees who are not in agreement with the decision reached by discussion, may then file a grievance in writing within 10 calendar days after receiving the informal decision of their immediate supervisor.

d. Employees are assured freedom from reprisal for using the grievance procedures established herein.

45. **DEFINITIONS.** a. **Dissatisfaction.** Anything that disturbs an employee, but has not been called to the attention of management.

b. **Complaint.** A spoken or written dissatisfaction, brought to the attention of management or employee representatives. It may or may not specifically assign a cause for dissatisfaction.

c. **Grievance.** A complaint that has been ignored, overridden, or in the employee's opinion otherwise dismissed without due consideration.

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d. **Personal Problem.** Any irritation or misunderstanding which is caused by factors, conditions, or personal relationships occurring outside the Department or Installation.

e. **Appointing Power.** The Adjutant General.

f. **Jurisdiction of Authority.** State employees may appeal to the State Department of Personnel Administration in matters over which the Adjutant General has only partial jurisdiction; in those instances, the employee will be advised by the Adjutant General that he may make further appeal to the State Personnel Board.

46. **LEVELS OF REVIEW.** a. **1st Formal Level.** Branch/Office Chiefs or comparable level. Normally immediate Supervisor's Supervisor. Base Engineer for ANG bases and Station Commanders for ANG stations.

(1) At Air Installations - Station Commander or Base Civil Engineer.

(2) At Army Installations custodial or maintenance employee whose immediate supervisor is an Army Custodian II or III - Area Coordinator.

(3) At Training Site - Post Commander.

(4) All other employees - The appropriate Director.

b. **2d Level.**

(1) ARNG Employees except those in Resource Management and Special Staff Division at OTAG - DAG Army.

(2) ANG Employees except those in Resource Management and Special Staff Division at OTAG - DAG Air.

(3) Resource Management Division Employees - DAG-RM.

(4) Special Staff - Chief of Staff.

c. **3d Level.** The Adjutant General.

47. **PROCEDURES.** a. The Standard Employee Grievance Forms, OTAG Form 900-26 and STD Form 630, Appendices GG and HH, will be submitted in duplicate and the following procedure will be used in processing a formal grievance:

(1) **1st Level of Review.** The grievance shall be presented in writing to the employee's immediate supervisor, who shall enter his decision and comments in writing and return the form to the employee within 15 calendar days after receiving the grievance. Failure of the employee to take further action within 10 calendar days after receipt of the decision, or within a total of 25 calendar days, if no decision is rendered will constitute a dropping of the grievance.

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(2) **2d Level of Review.** If the employee does not agree with his supervisor's decision, or if no answer has been received within 15 calendar days, the employee may present the grievance in writing to an intermediate level of supervision as designated by the appointing power. The supervisor receiving the grievance at this level shall review the grievance, enter his decision and comments in writing, and return the form to the employee within 15 calendar days after receiving the grievance. Failure of the employee to take further action within 10 calendar days after receipt of the decision, or within a total of 25 calendar days if no decision is rendered, will constitute a dropping of the grievance.

(3) **Final Review.** If the employee does not agree with the decision reached at the second level, or if no answer has been received within 15 calendar days, he may present the grievance in writing to the appointing power. The appointing power or his designated representative, if possible, should discuss the grievance with the employee, his representative, if any, and with other appropriate persons. The appointing power shall render a decision in writing to the employee within 20 calendar days after receiving the grievance.

b. The time limits specified above may be extended to a definite date by mutual agreement of the employee and the reviewer concerned.

c. The employee may request the assistance of another person of his own choosing in preparing and presenting his grievance. The employee and his representative if in the same agency, are entitled to use a reasonable amount of work time as determined by the appointing power in preparing and presenting the grievance and they shall be assured freedom from reprisal for using the grievance procedures.

### SECTION XIII - AWARDS

48. **SERVICE AWARDS.** Employees are presented a service award after having completed 25 and 40 years of State service.

49. **SUSTAINED SUPERIOR ACCOMPLISHMENT AWARDS.** a. The State Administrative Manual authorizes a \$250.00 cash award to selected employees who have sustained superior accomplishment for a period of at least 24 months. One cash award per 200 employees is the ratio that a Department may consider. A cash award recipient is not eligible for another cash award during a three year period following receipt of a cash award.

b. Any supervisor of a State Civil Service employee may nominate an employee for subject award. The State of California Form 278, Appendix II, Superior Accomplishment Award Recommendation, is the form to be used for nominations. This form may be procured from the OTAG State Personnel Programs Office. Nominations are submitted through channels to the President, Military Department Merit Awards Board. Supporting documentation such as letters of commendation, performance reports, etc., may accompany the recommendation. The reverse side of the State Form 278 provides recommending supervisors with a guide for preparation of the submission. The Merit Awards Board will consider the following:

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(1) The extent to which the nominee may have exceeded the basic or normal range of job performance standards for the position.

(2) The period of time over which the nominee sustained his/her level of work accomplishment.

(3) The relative importance of the superior work accomplishment toward the goals, objectives and missions of the Department.

(4) The difficulty, complexity and nature of the superior work performed.

(5) Relevant special circumstances such as difficult working conditions, newness of a program, etc.

c. The Military Department Merit Awards Board meets annually between 10 and 28 February. Therefore, nominations must be submitted in sufficient time to allow receipt by the Board not later than 9 February of each year. The composition of the Board is as follows:

(1) **President.** Appointed by the Adjutant General to serve in that capacity for a period of two years or until another individual is appointed.

(2) **Members.** A minimum of four in number. Appointed by the Adjutant General to serve two year terms each with the replacement of two members each year. Additional members may be appointed from time-to-time to ensure that a least four voting members at any particular Board are senior to all nominees being considered.

d. Presentations of Award(s) will be effected at a suitable ceremony by the Adjutant General or his designated representative.

50. **SUGGESTIONS AWARDS.** a. **Definition.** A suggestion is a proposal by one or more employees which will reduce or eliminate State expenditures or improve the operation of State Government. To qualify for consideration, a suggestion must do more than call attention to a problem; it also must set forth a constructive solution.

b. **Co-Suggesters.** When two or more suggesters submit a jointly-conceived idea for consideration, they will share equally in any award approved.

c. **Supervisory Participation.** If an immediate supervisor materially assists in the development of an idea, an award not to exceed 3% of the net annual savings may be paid to the supervisor, provided the savings are in excess of \$1,500. Such an award does not reduce the original award but is in addition thereto. A supervisor is not precluded from submitting a suggestion on his own or as a co-suggester.

d. **Amount of Awards.** An award, not to exceed 10% of the net annual savings, or benefits, may be paid. The initial award may be up to \$150 with Board of Control approval. With Legislative approval, an additional award may be granted. Before an award is granted for an adopted suggestion, the suggestion must be placed in effect.

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**e. Eligibility for Awards.** Awards will not be granted when:

(1) The idea suggested is currently under active consideration by the agency affected.

(2) The suggestion is a duplicate of one previously submitted.

(3) The suggestion is submitted more than six months after the idea was placed in effect.

(4) The suggestion pertains to a subject assigned to the suggester for research, development or solution or which he has a clear and specific responsibility to offer as part of his normal job requirements.

(5) The suggestion proposes that an agency follow existing policy or procedure when, through oversight, such policy or procedure was not being followed.

**f. Unacceptable Suggestions.** Some proposals will not be accepted for consideration. These are the one which:

(1) Express personal grievances.

(2) Recommend studies, surveys or reviews.

(3) Recommend changes in pay or classification.

(4) Give only unsupported personal preferences.

(5) Advocate increased taxes, license fees, or creation of additional revenue by imposition of an inequitable or unjust tax.

**g. Employee Rights.** Employees retain rights to suggestions for a period of one year from the date of the letter of non-adoption. If the suggestion is placed in effect during this one year period, employees may request reconsideration of their suggestion, provided they do so within six months of the date the idea was placed in effect. It must be established that the employee's suggestion was in some degree responsible for the improvement before an award can be made.

**h. Appeals and Renewals.** If a suggestion is not adopted and the employee is dissatisfied with the reasons for non-adoption, he/she may request reconsideration and renew such request annually for a period not to exceed three years from the date of the original letter of nonadoption. Employees must submit additional or supplemental information which was not previously covered or which points out an error in the evaluation report.

**i. Submission Procedures.**

(1) Type or print the required information in the spaces at top of STD Form 645, Appendix JJ.

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- (2) Use a separate form for each idea.
- (3) Explain the existing or previous method or condition.
- (4) Describe the idea in sufficient detail to enable review without requesting additional information.
- (5) Explain the advantages that will result.
- (6) Submit a sketch or sample if it will clarify your proposal.
- (7) Sign the suggestion form in the proper space. If co-suggesters, signature and other identifying information is required of each. If a Supervisory Participation suggestion, both the suggester and the supervisor must sign the statement on the reverse side of the suggestion blank.
- (8) Fold and seal the suggestion form, then place it in inter-departmental or U.S. Mail. The address is preprinted on the form.

#### XIV - AFFIRMATIVE ACTION/EQUAL EMPLOYMENT OPPORTUNITY

**51. EQUAL EMPLOYMENT OPPORTUNITY.** Equal Employment Opportunity provides the right for individuals to have equal access to employment. State and Federal law mandates that individuals should not be excluded from participation in any employment process, advancement or benefits in employment because of their race, color, religion, sex, national origin, age, disability, sexual orientation or any other factors which cannot lawfully be supported as the basis for employment action.

**52. AFFIRMATIVE ACTION.** Affirmative Action refers to specific actions undertaken to correct past discriminatory practices against women, ethnic minorities and disabled persons and to establish a balanced work force. To eliminate underrepresentation of these groups in an agency's work force, an employer institutes affirmative action by taking positive steps in recruiting, selecting and training staff.

**53. MILITARY DEPARTMENT PRACTICES.** a. The Military Department practices Equal Employment Opportunity in its entire selection process. In recruitment, examining procedures, and hiring interviews the departmental staff must be concerned only with job related factors. At no time do non-job related factors such as race, religion, disability, sex, national origin, age, disability or sexual orientation enter into the selection procedure.

**55. SEXUAL HARRASSMENT.** a. General. It is the policy of the Military Department to provide a neutral work environment free from unwelcome sexual overtures, advances and harrassment. Department employees are expected to adhere to a standard of conduct that is respectful and courteous to other

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**APPENDIX A**

**STATE OF CALIFORNIA  
MILITARY DEPARTMENT**

**STATE CIVIL SERVICE POSITION REQUEST**

- 1. DIVISION/ACTIVITY: \_\_\_\_\_
- 2. BRANCH/SECTION: \_\_\_\_\_
- 3. ACTION REQUEST: \_\_\_\_\_ New Position                      \_\_\_\_\_ Reclassify Position
- 4. PROPOSED TITLE/CLASS: \_\_\_\_\_  
PRESENT TITLE/CLASS: \_\_\_\_\_
- 5. JUSTIFICATION FOR ACTION: (Also attach duty statement)

- 6. REQUESTING OFFICIAL: \_\_\_\_\_
- 7. DIVISION/ACTIVITY APPROVAL: \_\_\_\_\_  
.....
- 8. STATE PERSONNEL PROGRAMS CONCURRENCE: \_\_\_\_\_
- 9. FUND VERIFICATION: \_\_\_\_\_
- 10. AG or DESIGNATED REPRESENTATIVE APPROVAL: \_\_\_\_\_

**STATE PERSONNEL PROGRAMS USE**

- a. Class: \_\_\_\_\_
- b. Unit/Serial #: TO: \_\_\_\_\_ FROM: \_\_\_\_\_
- c. 607 Number: \_\_\_\_\_ Date Prepared: \_\_\_\_\_

OTAG Form 900-21 (REVISED JAN 87) All prior forms are obsolete.

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**APPENDIX B**

**EMPLOYEE PROCUREMENT REQUEST**

- 1 DIVISION/ACTIVITY: \_\_\_\_\_
- 2 BRANCH/SECTION: \_\_\_\_\_
- 3 POSITION TO BE FILLED: \_\_\_\_\_
- 4 VICE: \_\_\_\_\_
- 5 EFFECTIVE DATE OF VACANCY: \_\_\_\_\_
- 6 ACTION REQUESTED:
  - \_\_\_\_\_ Publish vacancy announcement and provide application.
  - \_\_\_\_\_ Obtain list of eligibles from State Personnel Board
  - \_\_\_\_\_ Appoint \_\_\_\_\_ who is eligible for reinstatement.
  - \_\_\_\_\_ Other (Explain): \_\_\_\_\_
- 7 REQUESTING OFFICIAL: \_\_\_\_\_ DATE: \_\_\_\_\_
- 8 DIVISION/ACTIVITY APPROVAL: \_\_\_\_\_ DATE: \_\_\_\_\_
- 9 POSITION VERIFICATION: \_\_\_\_\_ DATE: \_\_\_\_\_  
State Personnel Programs Representative
- 10 FUNDS VERIFICATION: \_\_\_\_\_ DATE: \_\_\_\_\_  
Comptroller Representative
- 11 APPROVED: \_\_\_\_\_ DATE: \_\_\_\_\_  
AG or Designated Representative

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APPENDIX C

STATE OF CALIFORNIA

HEALTH QUESTIONNAIRE  
STD. 610 (11/82)

APPLICANTS ARE REQUIRED TO FILL IN  
QUESTIONS ON BOTH SIDES OF FORM  
ONLY AFTER A JOB OFFER  
HAS BEEN MADE

SOCIAL SECURITY NO. (optional)

THIS AREA TO BE COMPLETED BY HIRING AGENCY - COMPLETED QUESTIONNAIRE WILL BE RETURNED TO HIRING AGENCY				
NAME (LAST)	(FIRST)	(MIDDLE)	AGENCY NAME	
ADDRESS (STREET)	(CITY)	(STATE)	(ZIP CODE)	
CLASS TITLE			AGENCY ADDRESS	
TYPE OF APPOINTMENT		CURRENT OCCUPATION		
<input type="checkbox"/> PERMANENT	<input type="checkbox"/> REINSTATEMENT	DESIRED APPOINTMENT DATE		
<input type="checkbox"/> TAU	Dates of Previous State Employment			
<input type="checkbox"/> LIMITED TERM		TELEPHONE NO.		

THIS AREA TO BE COMPLETED BY THE APPLICANT

DO NOT LEAVE YOUR PRESENT EMPLOYMENT TO ACCEPT A POSITION IN STATE SERVICE UNTIL YOU HAVE BEEN SPECIFICALLY NOTIFIED TO REPORT FOR WORK. MEDICAL CLEARANCE IS REQUIRED PRIOR TO EMPLOYMENT IN STATE SERVICE.

Have you ever had or do you have the following:

Your answers to the following questions will be evaluated in conjunction with the essential functions of the desired position. In addition, a physical examination may be required. "YES" answers to questions 1 - 43 below must be explained in the space provided on the back of this form.

BIRTH DATE	<input type="checkbox"/> MALE	<input type="checkbox"/> FEMALE	HEIGHT	WEIGHT	
ITEM	YES	NO	ITEM	YES	NO
1. Do you wear or have you ever worn glasses?			26. Allergies		
2. Do you or have you ever worn contact lens?			27. Sensitivity to dust or smoke		
3. Have you had any eye injury, surgery, or disease?			28. High or low blood pressure		
4. Are you blind in one eye?			29. Varicose veins		
5. Are you blind in both eyes?			30. Stomach or duodenal ulcer or other bowel problem		
6. Lung or respiratory trouble, including bronchitis, tuberculosis, or asthma			31. Rupture or hernia		
7. Residuals of poliomyelitis			32. Gall bladder trouble		
8. Hepatitis, jaundice, or other liver ailments			33. Kidney or bladder trouble		
9. Cancer, malignant tumor or cysts			34. Shortness of breath		
10. Diabetes or sugar in urine			35. Do you wear a hearing aid or have you had at any time a problem with your hearing?		
11. Pernicious anemia, leukemia or other blood disorder or ailment			36. Any speech impairment		
12. Mental illness or nervous breakdown			37. History of or addiction to drugs or alcohol		
13. Any disorder of the nervous system			38. Any existing temporary medical condition such as broken bones, recovery from surgery, pregnancy, etc.? If yes, list condition and anticipated date of recovery.		
14. Seizure disorder or loss of consciousness			39. Are you at present under a doctor's care for any condition? Give reason and doctor's full name and address		
15. Severe headaches or migraines			40. Are you taking any medication now or in the last 12 months? If yes, what		
16. Heart trouble - including circulatory disease			41. Have you ever been hospitalized? If yes, list reason and date of hospitalization		
17. Rheumatic fever			42. a. Have you had an illness or injury which caused you to lose time from work?		
18. Any defect of bones or joints, including amputations, dislocations, broken bones			b. Does this illness or injury continue to limit your ability to perform certain types of work?		
19. Rheumatism, arthritis, or bursitis			43. Have you ever had any other illness, injury or physical condition not named above which required treatment as an outpatient or where surgery was recommended (exclude common minor illnesses, e.g., colds, flu, etc.)?		
20. Back pain or back injury					
21. Head injury					
22. Any problems with hips, knees, ankles or feet					
23. Any problems with hands, elbows, or shoulders					
24. Fainting spells or dizziness					
25. Skin trouble					

PRIVACY NOTICE - Official Responsible: Medical Officer, State Personnel Board, 801 Capitol Mall, Sacramento, CA 95814; Authority: Government Code Section 18931; Purpose: The information you furnish will be used to evaluate your medical fitness to carry out the duties of the position applied for without endangering the health and safety of yourself or others; Providing Information: Medical clearance is required prior to employment in State service; Effects of Not Providing Information: Omission or misrepresentation may result in placement in a position where the duties or work environment could be hazardous; Access: Your medical records will be maintained in a confidential manner and may be reviewed by contacting the employing agency's personnel office.

(OVER)



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APPENDIX C (continued)

STATE OF CALIFORNIA

**MEDICAL EXAMINATION REPORT  
(TO BE COMPLETED BY A LICENSED  
PHYSICIAN AND SURGEON)**

**TO THE PHYSICIAN.** The attached HEALTH QUESTIONNAIRE should be completed and submitted to you by the person whose name appears below. It is intended to assist you in the conduct of the examination. You are requested to complete the medical examination report. The Hiring Agency is responsible for payment of the fee. See page 4 for instructions.

SOCIAL SECURITY NO. (optional)

**ALL ITEMS BELOW ARE MANDATORY - COMPLETED REPORT SHOULD BE RETURNED TO HIRING AGENCY**

NAME (LAST)	(FIRST)	(MIDDLE)	AGENCY NAME
ADDRESS (STREET)	(CITY)	(STATE)	(ZIP CODE)
CLASS TITLE			AGENCY ADDRESS
TYPE OF APPOINTMENT <input type="checkbox"/> PERMANENT <input type="checkbox"/> REINSTATEMENT <input type="checkbox"/> TAU              Dates of Previous State Employment <input type="checkbox"/> LIMITED TERM		CURRENT OCCUPATION	TELEPHONE NO.
		DESIRED APPOINTMENT DATE	

**DOCTOR:** Write comments on any positive or negative findings for evaluation of applicant.  
(If more space is needed, use reverse of this form and/or a separate sheet of paper.)

1. HEIGHT  WEIGHT (WITHOUT HEAVY CLOTHING OR SHOES)	2. VISION <input type="checkbox"/> GLASSES <input type="checkbox"/> CONTACT LENSES				3. HEARING (Ordinary conversation at 15 feet considered normal)		AUDIOMETRY (if done)				
	UNCORRECTED		CORRECTED		RIGHT	LEFT	500	1000	2000	3000	4000
	NEAR	DISTANT	NEAR	DISTANT							
	Right 20/				/15	/15	Right				
Left 20/				HEARING AID USED <input type="checkbox"/> YES <input type="checkbox"/> NO		Left					
4. HEAD (eyes, ears, nose, mouth, throat)						5. (A) RESTING PULSE RATE		(B) BLOOD PRESSURE			
6. LUNGS (breath sounds, rates)				7. HEART (enlargement, rhythm, sounds) and circulatory system							
8. NERVOUS SYSTEM (reflexes, motor strength, atrophy, sensory changes or any abnormal reflexes)											
9. ABDOMEN (G.I. system, liver, spleen, masses, scars, hernias, etc.)						HERNIA					
10. GENITOURINARY SYSTEM INCLUDING KIDNEYS						11. RECTAL Fissure		Fistula		Hemorrhoids	
12. SPINE (deformity, tenderness, range of motion)						13. EXTREMITIES (strength, range of motion, deformities, atrophy or sensory changes)					
14. SKIN AND LYMPHATICS, SIGNIFICANT SCARRING						15. VARICOSE VEINS (severity)					
16. URINALYSIS SP. Gravity    Albumin    Sugar						17. SPECIFY ANY WORK LIMITATION					
18. PSYCHIATRIC EVALUATION (any mental disorder observed)											
19. SIGNATURE OF PHYSICIAN (REQUIRED)						20. NAME AND ADDRESS OF PHYSICIAN REQUIRED (Please Print)				TELEPHONE (REQUIRED)	
DATE											

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APPENDIX C (continued)

NOTICE TO PHYSICIANS AND CLINICS

The State of California requires preplacement physical examinations for certain classes of employment. The State also has many employees who are required to have a physical examination at the time of renewal of their Class I or II driver's license, when the possession of the license is required for the position.

REPORTS

The medical report should be sent to the Hiring Agency shown on Page 1, unless you are requested by the person examined to mail this medical report directly to the State Personnel Board Medical Office, 801 Capitol Mall, Sacramento, California 95814.

BILLINGS

Please send your bill (in triplicate) for this examination to the hiring agency as indicated on Page 1. If hiring agency is not identified, do not perform the examination. The State Personnel Board does not have the authority to pay for examinations.

The State Hiring Agency will pay the fee for this Medical Examination Report up to a maximum determined by the Department of Health Services and set forth in the State Administrative Manual (Section 0190.1). The current fee allowance may be obtained from the Hiring Agency shown on Page 1. If there should be additional studies or examinations required for more complete evaluation of the individual, these examinations will be at the expense of the applicant.

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APPENDIX D

CALIFORNIA STATE PERSONNEL BOARD



AUTHORIZATION  
FOR THE RELEASE OF MEDICAL INFORMATION

To: Any licensed physician, other licensed practitioner, hospital, and clinic or other medically related facility, United States Veterans Administration, or Selective Service, which are in the possession of medical records pertaining to:

(Name) \_\_\_\_\_

(Address) \_\_\_\_\_

In order to assist a determination of my employment with the State of California, I authorize you to copy and to transmit to the Medical Officer listed below any and all data and records concerning my physical or mental health with the following exceptions: \_\_\_\_\_

Medical Officer  
State Personnel Board  
801 Capitol Mall  
Sacramento, CA 95814  
Telephone (916) 445-7007

This authorization shall be valid for a period of 90 days after the date of my signature or earlier if revoked by me in writing to the State Personnel Board.

I hereby acknowledge that I have been informed of my right to receive a copy of this authorization upon request.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date



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## APPENDIX E (continued)

### INSTRUCTIONS

Expense accounts are to be submitted at least once a month and not more often than twice a month, except where the amount claimed is less than \$10, the claim need not be submitted until it exceeds \$10 or until June 30, whichever occurs first. Out-of-state travel expense will be claimed separately. A brief statement, one line if possible, of the purpose or objective of the trip will be entered on the line immediately below the last entry for each trip. If the claim is for several trips for the same purpose or objective, one statement will suffice for those trips. Vouchers which are required in support of various items of expense will be arranged in chronological order and attached to the claim. Each voucher must show the date and nature of the expense.

#### COLUMN ENTRIES

- (1) MONTH/YEAR - Enter numerical designation of month and last two digits of the year in which the first expenses shown on the form were incurred.
- (2) DATE/TIME - Enter date and time of departure on the appropriate line using twenty-four hour clock (examples: 0730, 1650). Show time of return on the date of return. If departure and return are on the same date, enter departure time above and return time below on the same line. Where the first date shown is a continuation of a trip, enter "Continuing" above that date, and where a trip is continuing beyond the last date shown, write "Continuing" after the last date.
- (3) LOCATION - Give the name of the city, town, or location where expense was incurred. Use "en route" only when a specific location is not identifiable. Abbreviations may be used.
- (4) SUBSISTENCE ALLOWANCES
  - IN-STATE TRAVEL - SHORT TERM. Enter the total amount of expenses authorized by Board of Control Rule 706(c) (1) and 706(c)(2) and detailed in the State Administrative Manual, Section 0762, for each 24-hour day.
  - PARTIAL DAYS TRAVEL. Enter specific amounts authorized by Board of Control Rules 706(c)(1) and detailed in SAM Section 0762. Use more than one line if necessary.
  - IN-STATE TRAVEL - LONG TERM AND NON-COMMERCIAL. Enter the amount authorized by Board of Control Rule 706(c)(3) and detailed in SAM Section 0763.
  - OUT-OF-STATE TRAVEL. Enter the total amount of expenses authorized by Board of Control Rule 706(d) and detailed in SAM Section 0762. Actual lodging expense may be claimed if supported by a receipt.
  - OVERTIME MEAL (authorized by Board of Control Rule 707) and BUSINESS RELATED MEAL (authorized by Board of Control Rule 708(f)). Enter the actual cost of the meal not to exceed the maximum amounts permitted by Board of Control Rule 706(c)(1) and SAM Section 0762. These claims must be supported by a receipt.
- (5) TRANSPORTATION - Purchase the least expensive round-trip or special rate ticket available. Otherwise the difference will be deducted from the claim. If you travel between the same points without using round-trip tickets, an explanation should be given.
  - (A) Enter cost of cash purchase of transportation. Show how transportation was furnished if ticket not purchased for cash. Use "CC" for credit card and "TO" for ticket order. Attach all passenger coupons and ticket order stubs including the unused portion of tickets or other credit documents where refunds are due.
  - (B) Show method of transportation used. Use "R" to indicate railway, "A" for scheduled airline, "PA" for privately-owned aircraft, "PC" for private car, "SC" for state car, "RC" for rental car, "B" for bus.
  - (C) Show points between which travel was made. Include "and return" if round-trip.
  - (D) Enter carfare, bridge tolls, and parking charges; detail such daily charges exceeding \$2.50 in item 7. Attach a voucher for any parking charge over \$3.50 for any one continuous period of parking.
  - (E) Enter number of miles traveled and amount due for mileage claimed for use of privately-owned automobiles.

Where use of a privately-owned automobile is authorized even though a state automobile is available, the rate in Board of Control Rule 714(a) and SAM Section 0755 is allowed. Where use of a privately-owned automobile has been authorized because a state automobile was not available, consult Board of Control Rule 714(b) and SAM Section 0755.
- (6) BUSINESS EXPENSE - Items of business expense include phone calls (for a long distance call show the place and party called in item 7 and if charge exceeds \$2.50, support by vouchers or other evidence), emergency purchases of equipment, clothing or supplies, travel expense of inmates, wards, or patients of institutions, and all other charges necessary to completion of the official business function.
- (7) REMARKS OR DETAILS - Explain unusual expenses. Enter detail or explanation of items in other columns, if necessary. Vouchers must be provided for any miscellaneous item of expense exceeding \$1 except those noted above.
- (8) When a claim for conference or convention expense under Board of Control Rule 708 is included, approval of the department head, his principal deputy or the chief administrative officer is required, either on a separate document attached to the claim or by signature in this block.

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**APPENDIX F**

**STATE CIVIL SERVICE PERSONNEL ACTION REQUEST**

- 1 ACTIVITY/LOCATION: \_\_\_\_\_  
2 BRANCH/SECTION: \_\_\_\_\_  
3 POSITION TITLE: \_\_\_\_\_  
4 TYPE OF APPOINTMENT: \_\_\_\_\_

- \_\_\_\_\_ New Appointment  
\_\_\_\_\_ Transfer from another State Department.  
Indicate Department \_\_\_\_\_  
\_\_\_\_\_ Reinstatement. Indicate previous classification, \_\_\_\_\_  
and Department \_\_\_\_\_  
\_\_\_\_\_ 60 Day Emergency, or Limited Term  
\_\_\_\_\_ Retired Annuitant  
\_\_\_\_\_ TAU

5 NAME OF INDIVIDUAL SELECTED: \_\_\_\_\_

6 EFFECTIVE DATE REQUESTED: \_\_\_\_\_

7 SUPPORTING DOCUMENTS ATTACHED:

- \_\_\_\_\_ a. Employee Action Request, STD 686  
\_\_\_\_\_ b. State Employee Race/Ethnicity Questionnaire, SPB Form 300-1070  
\_\_\_\_\_ c. Application, STD Form 678  
\_\_\_\_\_ d. Oath of Allegiance, STD Form 689  
\_\_\_\_\_ e. Designation of Person Authorized to Receive Warrants, STD Form 243  
\_\_\_\_\_ f. Health Benefits Plan Enrollment Form, HBD 12  
\_\_\_\_\_ g. Dental Enrollment Plan Authorization, STD Form 692  
\_\_\_\_\_ h. Vision Plan Enrollment Authorization, STD Form 700  
\_\_\_\_\_ i. Employee Orientation, OTAG Form 900-23  
\_\_\_\_\_ j. Military Service Information, OTAG Form 900-25  
\_\_\_\_\_ k. Federal Privacy Act Statement, OTAG Form 900-17  
\_\_\_\_\_ l. Incompatible Activities Statement, OTAG Form 900-24  
\_\_\_\_\_ m. Emergency Information Form, OTAG Form 900-7  
\_\_\_\_\_ n. State Employee Disability Questionnaire, Form T100-131  
\_\_\_\_\_ o. Acknowledgement of Receipt of Retirement Information, Form PERS-ADM 42

8 REQUESTING OFFICER: \_\_\_\_\_ DATE \_\_\_\_\_

OTAG FORM 900-18 (Revised Jan 87) ALL PRIOR FORMS ARE OBSOLETE

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APPENDIX G

STATE OF CALIFORNIA  
**EMPLOYEE ACTION REQUEST**  
STD. 686 (REV. 1/84)

PERSONNEL OFFICE USE

A	01 AGENCY	02 UNIT	03 ADD'L IDENTIFICATION
---	-----------	---------	-------------------------

Who is authorized to receive your pay warrant in case of death?  
Contact your personnel office to update your designee's name or  
(Class 11 form 783) See also retirement beneficiary information  
on reverse side of employee copy.

CHECK ONE OR MORE BOX(ES) AND COMPLETE LISTED SECTIONS. RETURN COMPLETED FORM TO YOUR PERSONNEL OFFICE. USE BALLPOINT PEN AND PRINT CLEARLY. NO CARBON REQUIRED.

B	<input type="checkbox"/> <b>New Employee</b> SECTIONS C, E, F, G, H, I	<input type="checkbox"/> <b>Withholding Allowance Change</b> SECTIONS C, E, I	<input type="checkbox"/> <b>Address Change</b> SECTIONS C, F, I	<input type="checkbox"/> <b>Name Change</b> (Attach Substantiation) SECTIONS C, D, I	<input type="checkbox"/> <b>Birthdate Correction</b> SECTIONS C, H, I
---	---	--	--	--	--

C	01 SOCIAL SECURITY NUMBER	02 EMPLOYEE LAST NAME	03 FIRST NAME AND MIDDLE INITIAL	D	NAME CHANGE FORMER NAME (Last, First and Middle)
---	---------------------------	-----------------------	----------------------------------	---	---

**WITHHOLDING ALLOWANCE CHANGE OR NEW EMPLOYEE** SEE ADDITIONAL TAX INFORMATION/INSTRUCTIONS ON FOURTH AND FIFTH COPY

**E** FEDERAL AND STATE ALLOWANCES - Allowances for age, special and tax credits (box 02, 03 and 04) cannot be claimed for California State withholding. If you claim any of these allowances for Federal withholding, you must also complete Part II. If you are exempt from withholding, complete Part IV only.

**MARITAL STATUS FOR TAX PURPOSES ONLY - CHECK ONE**

01  SINGLE (or married, but withhold at the single rate)  MARRIED

02  REGULAR ALLOWANCE(S) - Number of allowance(s) you are claiming for yourself, spouse, dependents, blindness and/or age.

03  SPECIAL ALLOWANCE - You may claim this allowance if you are single with only one employer, or married with only one employer and your spouse is not employed. Enter "1".

04  ADDITIONAL ALLOWANCE(S) - For itemized deductions and/or tax credits (see instructions on fourth copy)

05  TOTAL - Add the number of allowances you claimed in boxes 02 thru 04 and enter the total.

**II SPECIAL TREATMENT OF STATE ALLOWANCES** - Complete boxes 06 thru 09 if you wish your California State withholding to be different than what you claim for Federal withholding; or if you claim the special, age or credit allowances in Part I. IF BOXES ARE NOT COMPLETED, CURRENT SPECIAL TREATMENT (IF ANY) WILL BE CANCELLED.

**MARITAL STATUS FOR TAX PURPOSES ONLY - CHECK ONE**

06  SINGLE/ Joint Custody Head of Household (or married, but withhold at the single rate)  MARRIED  HEAD OF HOUSEHOLD

07  REGULAR ALLOWANCE(S) - Number of allowance(s) you are claiming for yourself, spouse, dependents, and/or blindness.

08  ADDITIONAL ALLOWANCE(S) - For itemized deductions and/or Joint Custody Head of Household (see instructions on fifth copy).

09  TOTAL - Add the number of allowances you claimed in boxes 07 and 08 and enter the total.

**III. ADDITIONAL WITHHOLDING** - Complete box 10 and/or 11 if you wish additional Federal and/or State tax withheld from your wages. PART I (and PART II, if your State allowance claim differs from your Federal) must be completed. The first deduction will be made from your earnings for the pay period in which this form is processed. IF BOXES ARE NOT COMPLETED, CURRENT DEDUCTIONS (IF ANY) WILL BE CANCELLED.

I hereby authorize the State Controller to deduct monthly from my wages the additional Federal and/or State tax amount specified below. I understand that if boxes are not completed, current deductions, if any, will be cancelled.

10	TOTAL MONTHLY DEDUCTION \$	FEDERAL ADDITIONAL WITHHOLDING	11	TOTAL MONTHLY DEDUCTION \$	STATE ADDITIONAL WITHHOLDING
----	-------------------------------	--------------------------------	----	-------------------------------	------------------------------

**IV. EXEMPTION FROM WITHHOLDING** - Complete box 12 if you are eligible to claim exemption from withholding. No Federal or State income tax will be withheld from your wages. DO NOT COMPLETE PARTS I, II or III.

12  I claim exemption from withholding because of no tax liability. Last year I did not owe any income tax and had a right to a full refund of ALL income tax withheld, AND this year I do not expect to owe any income tax and expect to have a right to a full refund of ALL income tax withheld.

If you are not having income tax withheld this year but expect to have a tax liability next year, you must file a withholding allowance claim by December 1 of this year.

This exemption will automatically expire on February 15 of next year unless you file a new certification by January 31 of next year.

**V. NON-TAXABLE WAGES** - Complete box 13 if wages you will receive are not subject to income tax withholding.

13  I claim that the wages I will be receiving from the State are either a 1) MINISTER OF THE GOSPEL, 2) FOSTER GRANDPARENT, or 3) NONIMMIGRANT ALIEN wages. Indicate reason (See General Information on Fourth page).

F	ADDRESS CHANGE OR NEW EMPLOYEE PRINT CLEARLY 01 EMPLOYEE ADDRESS (Street, Rural Route or P.O. Box)	02 CITY AND STATE	03 ZIP CODE	G	ADDRESS WITHHOLD IF YOU WISH TO REQUEST CONFIDENTIALITY OF YOUR ADDRESS OR CANCEL A PREVIOUS REQUEST, COMPLETE THE ATTACHED 686A (FIFTH COPY).
---	---	-------------------	-------------	---	---

G	NEW EMPLOYEE THIS INFORMATION MAY BE USED TO LOCATE PRIOR PUBLIC EMPLOYMENT SERVICE FOR STATE SERVICE CREDITS AND/OR RETIREMENT SYSTEM BENEFITS	01 LAST EMPLOYED BY CALIFORNIA STATE AGENCY OR CAMPUS OF	02 LAST NAME (if different)	03 SEPARATED MO YR	04 LAST EMPLOYED BY CALIFORNIA PUBLIC AGENCY OF (City, County, Public School or Utility, etc.)	05 LAST NAME (if different)	06 SEPARATED MO YR
---	---	--	-----------------------------	--------------------	--	-----------------------------	--------------------

H	NEW EMPLOYEE OR BIRTHDATE CORRECTION BIRTHDATE MO DAY YR	I	EMPLOYEE SIGNATURE I certify that the above information is true and correct and that I have read the pertinent sections on the fourth and fifth copies of this form. Under the penalties of perjury, I certify that the number of withholding exemptions and allowances claimed on this certificate does not exceed the number to which I am entitled. If claiming exemption from withholding, I certify that I incurred no tax liability for last year and that I anticipate that I will incur no liability this year. EMPLOYEE SIGNATURE DATE	J	PERSONNEL OFFICE USE REVIEWER'S SIGNATURE DATE PHONE NO.
---	--	---	---	---	--

White, Personnel/Payroll Services Div.—Yellow, Personnel—Pink, Employee

86 95022

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APPENDIX H

CALIFORNIA STATE PERSONNEL BOARD

STATE EMPLOYEE RACE/ETHNICITY QUESTIONNAIRE

(For All New Hires)

300-1070 St Empl Race/Ethnic Quest (9/82)

Date

INSTRUCTIONS:

1. This self-identification questionnaire is part of the new employee package. Self-identification means each employee has the opportunity to select which race/ethnic group he/she most closely identifies with. Complete promptly and return to the Personnel Office with your other hiring documents.

EMPLOYEE'S NAME (print)	SOCIAL SECURITY NUMBER	SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
-------------------------	------------------------	---

2. Please check the one box below which best describes your race/ethnicity and enter the one letter chosen (A through T or X) on this line: \_\_\_\_\_

If Hispanic, check:

- A.  Mexican, Mexican/American, Chicano
- B.  Puerto Rican
- C.  Cuban
- D.  Any Other Spanish/Hispanic

If Not Hispanic, check:

- E.  White
- F.  Black
- G.  Filipino
- H.  American Indian  
*(Specify Tribe)*
- I.  Japanese
- J.  Chinese
- K.  Korean
- L.  Vietnamese
- M.  Asian Indian
- N.  Eskimo
- O.  Aleut
- P.  Hawaiian
- Q.  Samoan
- R.  Guamanian/Chamorro
- S.  Other Asian
- T.  Other Pacific Islander
- X.  Other, Not Listed

3. Please check the method of identification

- A. Self-identification
- B. Department Designation (This is only used if the employee does not self-identify.)

PRIVACY STATEMENT  
FOR RACE/ETHNICITY QUESTIONNAIRE

AGENCY NAME: State Personnel Board Public Employment and Affirmative Action Division

UNIT RESPONSIBLE FOR MAINTENANCE: The Personnel Office of the employing State department.

AUTHORITY/PURPOSE: Government Code Section 19792 states that "The State Personnel Board shall: . . . (h) Maintain a statistical information system designed to yield the data and the analysis necessary for the evaluation of progress in affirmative action and equal employment opportunity with the state civil service . . ."

The data is encoded by the department Personnel Office and becomes part of the Employment History System kept by the State Controller's Office. It is shared only with the State Personnel Board and the employing department. No other disclosures on an individual-identifiable basis are made.

PROVIDING INFORMATION: It is preferable for each employee to indicate which race/ethnic group they most closely associate with.

EFFECTS OF NOT PROVIDING THE INFORMATION: Since Government Code Section 19792 requires the collection of race/ethnic origin from all employees, your Personnel Office will designate a race/ethnic code for you should you decline to self-identify.

ACCESS: The individual can access his/her own records through their Personnel Office.



APPENDIX I (continued)

Locations Where Tests May Be Given

Opposite item # 7 write the number of the city or place in which you prefer to take the written test. If the examination is not held there, provision will be made for you at the nearest available place.

Cities and Counties		
01 Alameda Co	23 Mendocino Co	40 San Luis Obispo Co
02 Alpine Co	24 Merced Co	42 Santa Barbara Co
03 Amador Co	25 Modoc Co	43 Santa Clara Co
04 Butte Co	27 Monterey Co	44 Santa Cruz Co
05 Colusa Co	28 Napa Co	45 Shasta Co
06 Colusa Co	29 Nevada Co	47 Siskiyou Co
08 Del Norte Co	30 Orange Co	48 Solano Co
09 El Dorado Co	31 Placer Co	49 Sonoma Co
10 Fresno Co	32 Riverside Co	50 Stanislaus Co
11 Humboldt Co	34 Sacramento Co	52 Tehama Co
12 Imperial Co	35 San Benito Co	54 Tulare Co
14 Inyo Co	36 San Bernardino Co	55 Tuolumne Co
15 Kern Co	37 San Diego Co	56 Ventura Co
17 Lake Co	38 San Francisco Co	57 Yuba Co
18 Lassen Co	39 San Joaquin Co	58 Yuba Co
66 Long Beach		
19 Los Angeles Co		

PRIVACY STATEMENT

AGENCY NAME: State Personnel Board (SPB)  
 UNIT RESPONSIBLE FOR MAINTENANCE: Exam Processing Unit, 801 Capitol Mall, P.O. Box 942331, Sacramento, CA 95834-3010.

AUTHORITY: Government Code Section 18934 establishes the statutory requirement for filing applications for examinations. Board Rule 174 requires such applications to be filed in the time, place, manner, and on the form specified in the examination announcement.

PURPOSE: The information you furnish will be used to determine whether you do or do not meet the entrance requirements and may be the basis for arriving at your final rating in the examination.

PROVIDING INFORMATION: Participation in an examination is voluntary. If you choose to participate, it is required that you provide your name, address, and complete items 1, 2, and 11. Other information requested on the application form is voluntary unless the class for which you are applying has specific requirements such as typing proficiency, licensure, education, experience, etc.

OTHER INFORMATION: During the course of an examination, you may be requested to provide additional information regarding your qualifications, preferences regarding work location, shift, etc., and medical/health background.

ACCESS: Your completed application and other examination-related information submitted to the State Personnel Board becomes confidential examination information and the property of the Board as provided by Government Code Section 18934. Due to its confidential nature such information will not be returned. Only authorized personnel directly involved in the selection process will be allowed access.

EDUCATION AND EXPERIENCE					
PLEASE READ THE REQUIREMENTS SECTION ON THE EXAMINATION BULLETIN BEFORE FILLING OUT THIS SIDE.					
12. EDUCATION		CIRCLE THE HIGHEST GRADE YOU COMPLETED 1 2 3 4 5 6 7 8 9 10 11 12		HIGH SCHOOL GRADUATE YES <input type="checkbox"/> NO <input type="checkbox"/>	PASSED HIGH SCHOOL EQUIVALENCY TESTS YES <input type="checkbox"/>
A. NAME AND LOCATION OF COLLEGE OR UNIVERSITY		COURSE OF STUDY		COMPLETED SEMESTER UNITS	COMPLETED QUARTER UNITS
				DEGREE	DATE COMPLETED
B. BUSINESS, CORRESPONDENCE, TRADE, OR SERVICE SCHOOLS		COURSE OF STUDY			
C. IF THE EXAMINATION FOR WHICH YOU ARE APPLYING HAS SPECIFIC COURSE REQUIREMENTS, INDICATED IN THE EXAMINATION ANNOUNCEMENT, LIST THE COURSES WHICH SATISFY THESE REQUIREMENTS.					
13. CURRENTLY VALID CERTIFICATES OF PROFESSIONAL OR VOCATIONAL COMPETENCE, LICENSES AND EXPIRATION DATES, MEMBERSHIP IN PROFESSIONAL ASSOCIATIONS. (Include date of completion if requested on the examination announcement.)					
14. EXPERIENCE. BEGIN WITH YOUR MOST RECENT EXPERIENCE. LIST ALL EXPERIENCE IN THE LAST SEVEN YEARS, INCLUDING U.S. MILITARY SERVICE. GIVE DETAILS ON THE EXPERIENCE WHICH YOU BELIEVE MEETS THE ENTRANCE REQUIREMENTS FOR THE EXAMINATION. GO BACK MORE THAN SEVEN YEARS IF NECESSARY. ALSO, LIST ANY VOLUNTEER EXPERIENCE WHICH YOU BELIEVE HELPS YOU MEET THE REQUIREMENTS OF THE CLASS FOR WHICH YOU ARE APPLYING. SHOW ACTUAL TIME NUMBER OF HOURS/DAY, NUMBER OF HOURS/WEEK SPENT IN SUCH EXPERIENCE WITH "VOLUNTEER" IN THE SPACE FOLLOWING SALARY.					
PERIOD OF EMPLOYMENT		JOB CLASSIFICATION AND MOST IMPORTANT DUTIES PERFORMED IF APPLICABLE USE CIVIL SERVICE CLASSIFICATION		NAME AND ADDRESS OF EMPLOYER	
APPOINTMENT DATE TO		CURRENT CLASSIFICATION AND RANGES IF APPLICABLE		REASON FOR LEAVING	
TOTAL _____ YR. _____ MO.		SALARY: \$ _____ PER _____			
FULL-TIME <input type="checkbox"/> PART-TIME <input type="checkbox"/>		DUTIES		REASON FOR LEAVING	
HOURS PER WEEK:					
FROM TO		CLASSIFICATION		NAME AND ADDRESS OF EMPLOYER	
TOTAL _____ YR. _____ MO.		SALARY: \$ _____ PER _____		REASON FOR LEAVING	
FULL-TIME <input type="checkbox"/> PART-TIME <input type="checkbox"/>		DUTIES			
HOURS PER WEEK:				REASON FOR LEAVING	
FROM TO		CLASSIFICATION			
TOTAL _____ YR. _____ MO.		SALARY: \$ _____ PER _____		REASON FOR LEAVING	
FULL-TIME <input type="checkbox"/> PART-TIME <input type="checkbox"/>		DUTIES			
HOURS PER WEEK:				REASON FOR LEAVING	
FROM TO		CLASSIFICATION			
TOTAL _____ YR. _____ MO.		SALARY: \$ _____ PER _____		REASON FOR LEAVING	
FULL-TIME <input type="checkbox"/> PART-TIME <input type="checkbox"/>		DUTIES			
HOURS PER WEEK:				REASON FOR LEAVING	
FROM TO		CLASSIFICATION			
TOTAL _____ YR. _____ MO.		SALARY: \$ _____ PER _____		REASON FOR LEAVING	
FULL-TIME <input type="checkbox"/> PART-TIME <input type="checkbox"/>		DUTIES			
HOURS PER WEEK:				REASON FOR LEAVING	

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APPENDIX J

STATE OF CALIFORNIA

OATH OF ALLEGIANCE AND DECLARATION OF PERMISSION TO WORK  
FOR PERSONS EMPLOYED BY THE STATE OF CALIFORNIA

SYD-ARH (REV. 7-78)

(Complete Parts 1 and 3 or Parts 2 and 3)

PART 1 - OATH OF ALLEGIANCE

WHO MUST SIGN OATH - Every State employee before he/she enters upon the duties of his/her State employment, except legally employed noncitizens. The oath is not required of noncitizens; however, the Declaration of Permission to Work is required. If an alien employee becomes a naturalized citizen, an oath must then be obtained and filed.

WHEN OATH MUST BE SIGNED - Before entering upon the duties of their employment. For intermittent, temporary or emergency employments an oath or affirmation may, at the discretion of the employing agency, be effective for all successive periods of employment which commence within one calendar year from the date of the oath.

WHERE OATHS ARE FILED - All oaths for State employees, State Civil Defense Volunteers, members of the California National Guard or California Defense and Security Corps shall be filed in the official employee file within 30 days of the date the oath is executed.

FAILURE TO SIGN OATH - No compensation or reimbursement for expenses incurred shall be paid to any public employee or civil defense worker by any public agency unless such public employee or civil defense worker has taken and subscribed to the oath or affirmation.

PENALTIES (Government Code)

"3108. Every person who, while taking and subscribing to the oath or affirmation required by this chapter, states as true any material matter which he/she knows to be false, is guilty of perjury, and is punishable by imprisonment in the state prison not less than one nor more than 14 years."

(TYPE OR PRINT NAME OF EMPLOYEE)

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.

PART 2 - DECLARATION OF PERMISSION TO WORK

I am a lawful permanent resident alien of the United States.  YES  NO

If NO, please read the following:

I hereby certify, that I have permission to work in this country and have declared any restrictions placed upon me in this regard by the United States government to the appointing power.

PART 3 - SIGNATURE AND CERTIFICATION (NO FEE MAY BE CHARGED FOR ADMINISTERING)

SIGNATURE OF EMPLOYEE

STATE DEPARTMENT OR AGENCY

SUBDIVISION OR UNIT

Taken and subscribed before me this

\_\_\_\_ day of \_\_\_\_\_

SIGNATURE OF AUTHORIZED OFFICIAL

TITLE

(SEAL)

Oath may be administered by a person having general authority by law to administer oaths - or may be administered by the appointing power, or by a person for whom written authorization to witness oaths has been executed by the appointing power. The appointing power maintains a file of such authorizations.

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APPENDIX K

STATE OF CALIFORNIA <b>DESIGNATION OF PERSON AUTHORIZED TO RECEIVE WARRANTS (Gov. C., Sec. 12479)</b> STO. 249 (REV. 4/78) NAME OF EMPLOYING STATE AGENCY	NAME OF EMPLOYEE (FIRST, MIDDLE, LAST)
	SOCIAL SECURITY NO.
	CITY WHERE AGENCY LOCATED

Pursuant to Section 12479 of the Government Code, I hereby designate the following person who, notwithstanding any other provision of law, shall be entitled upon my death to receive all state warrants, excluding warrants for payment of death benefits and refund of employee retirement contributions, that would have been payable to me had I survived:

<b>DESIGNEE</b> (Must be at least 18 yrs old)			
NAME (FIRST, MIDDLE, LAST)	RELATIONSHIP	AGE	TELEPHONE NUMBER
ADDRESS	CITY AND STATE	ZIP CODE	

I hereby revoke any previous designations filed by me.

If the above-named designee does not file a written request with the personnel office of my employer state agency for such warrants within sixty (60) days after the date of my death this designation shall be and become null and void.

This designation will remain in full force and effect during my employment with any California state agency until revoked in writing by me. This designation will terminate on the date of my permanent separation from said employment.

SIGNATURE OF EMPLOYEE ▶	<b>FOR AGENCY USE ONLY</b>	
ADDRESS	REVIEWED BY THE AGENCY PERSONNEL OFFICE AND FILED	
CITY, STATE, ZIP CODE	SIGNATURE OF AGENCY PERSONNEL OFFICER ▶	
DATE SIGNED	TYPED NAME	DATE

INSTRUCTIONS

1. Complete this form in duplicate; typewritten or in ink.
2. Show designee's full name; for example, "Mary Jane Smith," not Mrs. John E. Smith.
3. Show relationship of the person being designated such as wife, husband, daughter, son, mother, father, friend, etc.
4. Verify that the form is complete and correct. No erasures or corrections may be made in the writing of the name of the designee. If any error has been made, complete a new set of forms.
5. Sign both copies in ink. Submit both copies to your personnel office. The duplicate copy will be returned to you for your record.
6. You may change your designation at any time, by filing a new designation with your personnel office.
7. You may completely revoke a designation at any time by a letter to your employer signed by you in duplicate.
8. Inform your personnel office when a change occurs in your designee's address.
9. You may wish to file a new designation upon any change in your marital status.

REFERENCE: Government Code Section 12479  
State Administrative Manual Sections 8429-8429.37

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APPENDIX L



Public Employees' Retirement System  
Post Office Box 734  
Sacramento, CA 95804-0734

PERS USE ONLY—DOCUMENT REFERENCE NUMBER

HEALTH BENEFITS PLAN ENROLLMENT FORM

PERS—HBD12 (Rev. 6/85)

PLEASE TYPE

1. TYPE OF ACTION (Check One) <input type="checkbox"/> a. NEW enrollment <input type="checkbox"/> b. CHANGE of coverage <input type="checkbox"/> c. CANCEL all coverage		2. SOCIAL SECURITY NUMBER — — — — —		A C C O U N T	LIST ALL PERSONS (including self) TO BE ENROLLED IN:			DATE OF BIRTH			Family Relationship	C O D E	
3. SPOUSE'S SOCIAL SECURITY NUMBER — — — — —		17. BASIC PLAN (FIRST) (MI) (LAST)			Mo.	Day	Yr.	SELF					
4. Name No. and Street City, State, ZIP (FIRST) (MI) (LAST)													
5. <input type="checkbox"/> Please check if Permanent Intermittent Employee (applies to active State employees only)		6. SEX <input type="checkbox"/> Male <input type="checkbox"/> Female		7. MARRIED <input type="checkbox"/> Yes <input type="checkbox"/> No									
8. PLAN CODE		9. NAME OF HEALTH PLAN											
10. GROSS PREMIUM \$		11. FACILITY (if applicable)											
12. PRIOR PLAN CODE		13. PRIOR HEALTH PLAN											
14. Permitting Event Code		15. Permitting Event Date Mo. Day Year		16. EFFECTIVE DATE Mo. Day Year		18. SUPPLEMENTAL PLAN (FIRST) (MI) (LAST)			DATE OF BIRTH			Relation-ship	C O D E
						Mo.	Day	Yr.					

19. CHECK ONE

- I DO NOT wish to enroll in a Health Benefits Plan under the Public Employees' Medical and Hospital Care Act.
- I elect to ENROLL IN (OR CHANGE TO) a Health Benefits Plan as shown in Items 8 and 9 above and authorize deductions to be made from my salary or retirement allowance to cover my share of the cost of enrollment as it is now or as it may be in the future. I also certify that the names of all dependents listed above in Items 17 and/or 18 are eligible family members as defined in the Public Employees' Medical and Hospital Care Act.
- I elect to CANCEL the Health Benefits Plan as shown in Items 12 and 13 above.

20. EMPLOYEE OR ANNUITANT'S SIGNATURE (see privacy information on reverse of employee copy)	21. DATE SIGNED Mo. Day Yr.
---	--------------------------------

PLEASE REFER TO THE HEALTH BENEFITS PROCEDURE MANUAL FOR COMPLETION OF ITEMS 22-27

22. DEDUCTION PLAN CODE	23. Type of action (Check One) 1. <input type="checkbox"/> New 2. <input type="checkbox"/> Cancel 3. <input type="checkbox"/> Change	24. PAY PERIOD Month Year	25. PARTY CODE	26. EMPLOYEE DESIGNATION	27. BARGAINING UNIT
28. AGENCY NAME (or Retirement System)			29. PAYROLL OFFICE CODE	30. AGENCY CODE	31. UNIT CODE
32. I hereby certify under penalty of perjury as follows: SIGNATURE OF HEALTH BENEFITS OFFICER			33. Date received in employing office Mo. Day Yr.		34. PHONE NUMBER ( )

That I am a duly appointed, qualified and acting officer of the above named agency, and that payment by the agency as provided by Sections 22825-22832 of the Government Code is hereby approved. Final determination of eligibility for the enrollment action specified will be made by the Board of Administration, Public Employees' Retirement System, in accordance with the Public Employees' Medical and Hospital Care Act and the regulations implementing the Act.

35. REMARKS

HBD

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APPENDIX M

STATE OF CALIFORNIA  
DENTAL PLAN ENROLLMENT AUTHORIZATION

STD 692 (REV 6/84)

PLEASE TYPE OR USE BALL POINT PEN, PRINT CLEARLY — SEND COMPLETED FORM TO PERSONNEL/PAYROLL OFFICE

SECTION A

SEE PRIVACY NOTICE ON REVERSE OF EMPLOYEE COPY

1. TYPE OF ACTION (CHECK ONE)

1.  NEW — ENROLLING IN A PLAN FOR THE FIRST TIME (COMPLETE SECTIONS A, B, AND D)

2.  CANCEL — CANCELLING COVERAGE FOR ALL ENROLLEES (COMPLETE SECTIONS A, C, AND D)

3.  CHANGE — CHANGING PLANS OR DEPENDENT COVERAGE (COMPLETE SECTIONS A, B, C, AND D)

2. SOCIAL SECURITY NUMBER

3. MARITAL STATUS  
 MARRIED  SINGLE

4. SEX  
 MALE  FEMALE

5. Name in Full  
FIRST MIDDLE LAST

6. Mailing Address  
NUMBER AND STREET CITY COUNTY STATE ZIP CODE

SECTION B (DO NOT COMPLETE THIS SECTION IF THE CANCEL BOX IN SECTION A IS CHECKED)

1. Name of Dental Plan

2. Provider/Facility Number (if applicable)

3. When changing family member enrollment, list all family members currently enrolled, as well as family members to be added and/or deleted. Enter the action code A (add) and/or D (delete) beside the names of only those family members to be added or deleted.

SEX	LIST ALL PERSONS TO BE ENROLLED IN DENTAL PLAN (INCLUDE SELF)			DATE OF BIRTH			FAMILY RELATIONSHIP	ACTION	CONTRIBUTION OF NAMES OF PERSONS TO BE ENROLLED			DATE OF BIRTH			FAMILY RELATIONSHIP
	FIRST	MIDDLE	LAST	NO.	DAY	YEAR			FIRST	MIDDLE	LAST	NO.	DAY	YEAR	
							SELF								

SECTION C

1. Prior Dental Plan Name

SECTION D

1. CHECK APPROPRIATE BOX

a.  I do not wish to enroll in a dental plan.

b.  I elect to enroll in (or change to) a dental plan as shown above and authorize deductions to be made from my salary or retirement allowance to cover my share of the cost of enrollment as it is now or as it may be in the future.

c.  I elect to cancel the dental plan shown above.

2. EMPLOYEE'S OR ANNUITANT'S SIGNATURE

3. DATE SIGNED

SECTION E (FOR AGENCY OR RETIREMENT SYSTEM USE ONLY)

1. EMPLOYER ORS CODE <input type="checkbox"/> CSU 180 <input type="checkbox"/> NON CSU 100	2. DENTAL PLAN ORS CODE	3. EMPLOYEE DEDUCTION AMOUNT	4. PARTY CODE	5. STATE SHARE AMOUNT	6. EFFECTIVE DATE OF ACTION - 1 -	7. EMPLOYEE DESIGNATION	8. BARGAINING UNIT	9. TOTAL PREMIUM AMOUNT
COMPLETE ON CANCELLATIONS ONLY		10. PRIOR EMPLOYER ORS CODE <input type="checkbox"/> CSU 180 <input type="checkbox"/> NON CSU 100	11. PRIOR DENTAL PLAN ORS CODE	12. PERMITTING EVENT DATE NO. DAY YR	13. PERMITTING EVENT CODE	14. AGENCY CODE	15. UNIT CODE	16. AGENCY NAME OR RETIREMENT SYSTEM IF RETIRED

17. REMARKS

18.  CHECK IF PERMANENT INTERMITTENT EMPLOYEE

19. AUTHORIZED AGENCY SIGNATURE  
I hereby certify under penalty of perjury as follows: That I am the duly appointed, qualified and acting officer of the herein named agency and that I am authorized to make this certification that the employee named herein is eligible for enrollment in the State dental insurance program.

20. TELEPHONE NUMBER  
INDICATE IF ATSS OR GIVE AREA CODE

21. DATE RECEIVED IN EMPLOYING OFFICE  
NO. DAY YR

WHITE—To Controller      YELLOW—To Carrier      PINK—To Agency      GREEN—To Employee

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APPENDIX M (continued)

**PRIVACY NOTICE**

The Information Practices Act of 1977 (Civil Code Section 1798.17) and the Federal Privacy Act (Public Law 93-579) require that this notice be provided when collecting personal information from individuals.

Information requested on this form is used by the State Controller's Office and the dental insurance company for the purposes of identification and dental coverage processing.

It is mandatory to furnish all information requested on this form except for employee's gender and marital status and spouse's birthdate, which may be furnished on a voluntary basis and are used by the dental insurance company for statistical and actuarial purposes. Failure to provide the mandatory information may result in the dental enrollment action not being processed or being processed incorrectly.

The State Controller's Office requires employee's social security number and name for identification purposes. Legal references authorizing maintenance of this information include Government Code Sections 1156 and 22950-22952, Sections 6011 and 6051 of the Internal Revenue Code, and Regulation 4, Section 404.1256, Code of Federal Regulations, under Section 218, Title II of the Social Security Act.

Information provided on the form will be forwarded to the dental insurance company providing coverage for the employee. Copies of the Dental Enrollment Authorization are maintained in confidential files of the State Controller's Office for five years. Employees have the right of access to copies of their Dental Enrollment Authorization forms upon request. The official responsible for the maintenance of the forms is: Chief of Payroll Services Section, Personnel/Payroll Services Division, State Controller's Office, 1900 Capitol Avenue, Sacramento, California 95814-5878, Telephone Number (916) 322-7950.

Upon retirement, your employer will forward this form to the Public Employees' Retirement System. The above information coincides with the purposes for which the Public Employees' Retirement System uses this form except that 1) the legal reference authorizing the System's collection of this information is Government Code Sections 20000, et seq. and 2) annuitants may request access to their Dental Enrollment Authorization by contacting the Information Coordinator, PERS, 1416 9th Street, P.O. Box 1953, Sacramento, California 95809, Telephone Number (916) 322-0985.

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APPENDIX N

STATE OF CALIFORNIA

VISION PLAN ENROLLMENT AUTHORIZATION



PLEASE TYPE OR USE BALL POINT PEN. PRINT CLEARLY. SEND COMPLETED FORM TO PERSONNEL/PAYROLL OFFICE

SECTION A SEE PRIVACY NOTICE ON REVERSE OF EMPLOYEE COPY

1. TYPE OF ACTION (CHECK ONE)

1.  NEW ENROLLING IN A PLAN FOR THE FIRST TIME (COMPLETE SECTIONS A, B, AND D)

2.  CANCEL CANCELLING COVERAGE FOR ALL ENROLLEES (COMPLETE SECTIONS A, C, AND D)

3.  CHANGE CHANGING PLANS OR DEPENDENT COVERAGE (COMPLETE SECTIONS A, B, C, AND D)

2. SOCIAL SECURITY NUMBER

3. MARITAL STATUS  
 MARRIED  SINGLE  MALE  FEMALE

4. SEX

5. Name in Full (FIRST MIDDLE LAST)

6. Mailing Address (NUMBER AND STREET CITY COUNTY STATE ZIP CODE)

SECTION B (DO NOT COMPLETE THIS SECTION IF THE CANCEL BOX IN SECTION A IS CHECKED)

1. Name of Vision Plan

2. Provider/Facility Number (if applicable)

3. When changing family member enrollment, list all family members currently enrolled, as well as family members to be added and/or deleted. Enter the action code A (add) and/or D (delete) beside the names of only those family members to be added or deleted.

ACTION CODE	LIST ALL PERSONS TO BE ENROLLED IN VISION PLAN (INCLUDE SELF)			DATE OF BIRTH			FAMILY RELATIONSHIP	ACTION CODE	CONTINUATION OF NAMES OF PERSONS TO BE ENROLLED			DATE OF BIRTH			FAMILY RELATIONSHIP
	FIRST	MIDDLE	LAST	MO	DAY	YEAR			FIRST	MIDDLE	LAST	MO	DAY	YEAR	
							SELF								

SECTION C

1. NAME OF VISION PLAN BEING CANCELLED OR CHANGED

SECTION D

1. CHECK APPROPRIATE BOX

- a.  I do not wish to enroll in a vision plan.
- b.  I elect to enroll in (or change to) a vision plan as shown above and authorize deductions to be made from my salary to cover my share of the cost of enrollment as it is now or as it may be in the future.
- c.  I elect to cancel the vision plan shown above.

7. EMPLOYEE'S SIGNATURE

8. DATE SIGNED

SECTION E (FOR AGENCY USE ONLY)

1. EMPLOYER DED CODE <input type="checkbox"/> CSU 450 <input type="checkbox"/> NON-CSU 475	2. VISION PLAN CODE ORG. CODE	3. PARTY CODE	4. EMPLOYEE DEDUCTION AMOUNT \$	5. STATE SHARE AMOUNT \$	6. EFFECTIVE DATE OF ACTION - 1 -	7. EMPLOYEE DESIGNATION	8. BARGAINING UNIT	9. TOTAL PREMIUM AMOUNT \$
10. PRIOR EMPLOYER DED CODE <input type="checkbox"/> CSU 450 <input type="checkbox"/> NON-CSU 475	11. PRIOR VISION PLAN CODE ORG. CODE	12. PERMITTING EVENT DATE MO. DAY YR.	13. PERMITTING EVENT CODE	14. AGENCY CODE	15. UNIT CODE	16. AGENCY NAME		

17. REMARKS

18.  CHECK IF PERMANENT/INTERMITTENT EMPLOYEE

19. AUTHORIZED AGENCY SIGNATURE  
I hereby certify under penalty of perjury as follows: that I am the duly appointed, qualified and acting officer of the herein named agency and that I am authorized to make this certification. That the employee named herein is eligible for enrollment in the State vision insurance program.

20. TELEPHONE NUMBER (INDICATE IF ATSS OR GIVE AREA CODE)

21. DATE RECEIVED IN EMPLOYING OFFICE  
MO DAY YR

WHITE - TO CONTROLLER PINK - TO CARRIER BLUE - TO AGENCY CANARY - TO EMPLOYEE

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## APPENDIX O

### EMPLOYEE ORIENTATION

#### INITIAL

- \_\_\_ 1. Collective Bargaining Unit \_\_\_\_\_
- \_\_\_ 2. Hours of Work:
  - a. Starting time: \_\_\_\_\_ Stopping time: \_\_\_\_\_
  - b. Lunch period (from): \_\_\_\_\_ (to): \_\_\_\_\_
  - c. Coffee breaks (A.M.) from: \_\_\_\_\_ to: \_\_\_\_\_  
(P.M.) from: \_\_\_\_\_ to: \_\_\_\_\_
  - d. Time of reporting absences to supervisor: \_\_\_\_\_
  - e. Absences less than 3 days, report to: \_\_\_\_\_
  - f. Absences 3 or more days, report to: \_\_\_\_\_
- \_\_\_ 3. Salary:
  - a. Starting salary: \_\_\_\_\_
  - b. Salary anniversary dates: \_\_\_\_\_
  - c. Regular paydays: \_\_\_\_\_
  - d. Approximate date of first check: \_\_\_\_\_
- \_\_\_ 4. Sick Leave, Vacation, and Personal Holiday:
  - a. Sick Leave - Accrual, Usage (self, family, bereavement)
  - b. Vacation - Accrual, Usage.
  - c. Personal Holiday.
- \_\_\_ 5. Attendance Reporting:
  - a. Pay periods
  - b. Preparation of STD Form 634
  - c. Instructions for mailing, dates due
  - d. Overtime and Compensating Time-off
- \_\_\_ 6. Miscellaneous Absences:
  - a. Jury Duty - Payment
  - b. Military Leave - Eligibility
  - c. Leave Without Pay
  - d. Holidays
- \_\_\_ 7. Probationary Period and Reports
- \_\_\_ 8. Performance Appraisal and Individual Development Plan
- \_\_\_ 9. Grievance Procedure (see appropriate Employee Organization Contract)
- \_\_\_ 10. Compulsory Payroll Deduction:
  - a. Tax
  - b. Retirement
  - c. Social Security

OTAG Form 900-23 (Revised Jan 87) ALL PRIOR FORMS ARE OBSOLETE

APPENDIX O (continued)

EMPLOYEE ORIENTATION - Page 2

INITIAL

- \_\_\_\_\_ 11. a. Optional Payroll Deductions:
  - (1) Basic and Major Medical Insurance
  - (2) Dental Insurance
  - (3) Vision Insurance
  - (4) Medicare
  - (5) Bonds
  - (6) United Funds
  - (7) Deferred Compensation
- \_\_\_\_\_ b. Employee Organization Dues
  - (1) Fair Share
  - (2) Life Insurance
  - (3) Income Protection Insurance
  - (4) Miscellaneous Insurance
- \* \_\_\_\_\_ 12. Promotional opportunities, eligibility and testing
- \_\_\_\_\_ 13. Use of telephone for personal calls - No long distance calls permitted
- \_\_\_\_\_ 14. State property procedures; Requisition Forms; Stamps, etc.
- \* \_\_\_\_\_ 15. In case of on-the-job injury, call: \_\_\_\_\_  
(Supervisor)
- \* \_\_\_\_\_ 16. Employee questions answered

Items checked were discussed: \_\_\_\_\_  
(date)

Signed: \_\_\_\_\_ Signed: \_\_\_\_\_  
(Supervisor) (Employee)

\_\_\_\_\_  
(Address)

\_\_\_\_\_  
(City, State, Zip)

( ) \_\_\_\_\_  
(Telephone)

\*Items to be discussed at annual evaluation

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**APPENDIX P**

**MILITARY SERVICE INFORMATION**

To be completed by employees who are current members of The National Guard or Reserve Components who may be eligible for Military Leave entitlements.

1. Conditions for Military Leave

Employees are entitled to 30 days Military Leave per fiscal year providing he/she qualify under the following conditions:

a. have not had a break in the continuity of State service

AND

b. have 12 qualifying pay periods of State service immediately prior to the effective date of active duty;

OR

c. a combination of State service and active Federal Military service prior to 14 September 1976 which equals one year.

2. List qualifying service below and attach documents to verify Military service:

Service or component	From			To		
	Day	Month	Year	Day	Month	Year
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____

AUTHENTICATION BY  
STATE PERSONNEL OFFICE

SIGNATURE \_\_\_\_\_

\_\_\_\_\_

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## APPENDIX Q

### Federal Privacy Act Information Statement

The Board of Administration, Public Employee's Retirement System, requires the disclosure of each member's Social Security account number on a mandatory basis to comply with Sections 6033 and 6041, Title 26, of the United States Code, and Sections 1.603-1(a)(3) and 1.604-2(b) of the Federal Tax Regulations, requiring reporting to the Internal Revenue Service of disbursements made by the System and to comply with its obligations under the Federal-State agreement imposed by Sections 404.1242, 404.1243, 404.1250, 404.1255 and 404.1256, Title 20, Code of Federal Regulations, requiring reporting to the Social Security Administration.

The Social Security account number is used for the following purposes and is included in the following documents:

1. Member identification on membership files, documents, and correspondence.
2. Annual report to the Franchise Tax Board and to the Internal Revenue Service of interest on refunds where the interest paid to an individual is \$600 or more.
3. Annual Statement of Member Contribution and Service Credit sent to employers for distribution to members.
4. Annual Listing of Member Contributions as of each June 30 sent to each employer.
5. All Refund Rolls submitted to the State Controller for processing.
6. Reports of benefit payments to the State Franchise Tax Board and to the Internal Revenue Service.
7. Annual return filed with the Internal Revenue Service.
8. Reports to the Internal Revenue Service of Federal income tax withheld from benefit payments.
9. Reports submitted to the Social Security Administration.

I have read the foregoing on \_\_\_\_\_  
(date)

\_\_\_\_\_  
(Signature)

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## APPENDIX R

### INCOMPATIBLE ACTIVITIES STATEMENT

1. Each State agency is required to establish a statement of incompatible activities of employees and to advise employees periodically of those activities considered incompatible with State employment. The following activities are considered incompatible for State employees of the Military Department:

a. Providing confidential information to persons to whom issuance of such information has not been authorized, or using confidential information for personal gain or advantage or for the advantage of others.

b. Soliciting or accepting, directly or indirectly, any money, loan, employment, business, benefit or other thing of value (in addition to salary paid by the State) from anyone from whom it might be inferred as a gift to influence the State employee concerned.

c. Engaging in any employment which will prevent prompt response to a call to report to duty as required by department heads.

d. Providing, or using, the names of persons from office records for mailing list that has not been authorized.

e. Providing, or using, unit station lists for use in circulation or advertising of articles or services.

f. Using the prestige or influence of one's office for personal gain or advantage or for the advantage of others.

g. Using State time, facilities, records, equipment or supplies for personal use or gain.

h. Receiving or accepting money, gifts or favors for services rendered during State working hours.

i. Performance of an unofficial act that may later be subject to the officer's control, inspection, review, audit or enforcement in an official State capacity.

2. In addition to the above activities, employees are also reminded that the Government Code of the State of California prohibits the use of any public office or employment to either aid or obstruct any person from obtaining any elected position or from nomination for an elected position.

3. In order to insure that all employees of the Department are aware of the incompatible activities the inclosure one is provided for each employee to acknowledge receipt of this letter. Signed acknowledgements should be returned to this headquarters, attention: CASS.

I acknowledge that I have read and understand the above statement.

---

Name

---

Activity, Section, Branch, or Installation

---

Date

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APPENDIX T

CALIFORNIA STATE PERSONNEL BOARD

EMPLOYEE TO COMPLETE:  
SOCIAL SECURITY NUMBER

STATE EMPLOYEE DISABILITY QUESTIONNAIRE  
T SPB 131 (1/86)

PRIMARY DISABILITY CODE \_\_\_\_\_

Code Primary Disability in first line.  
Code Secondary Disability(ies) on second line(s).

SECONDARY DISABILITY CODE(S) \_\_\_\_\_

**INSTRUCTIONS:** When indicating a disability, the following definition must apply. A disabled person is anyone who:  
(a) has a physical or mental impairment which substantially limits one or more major life activities;  
(b) has record of such impairment; or  
(c) is regarded as having such an impairment.

A person is substantially limited if such person is likely to experience difficulty in securing, retaining, or advancing in employment because of a disability.

Please enter your social security number where indicated above and review the following list of impairments and descriptions. If you have a disability, enter the code letter which best describes it following "Disability Code" above.

If you do not have a disability, please enter the letter "X" in the Primary "Disability Code" box above.

CODE	FACTORS	CODE	FACTORS
<input type="checkbox"/> A	Visual: Legal blindness in one or both eyes; acuity after correction (eye glasses or contact lenses) is 20/200 visual acuity or restriction in the visual field to 20 degrees.	<input type="checkbox"/> M	Respiratory Impairment: Unstabilized condition resulting in periodic breathing limitations.
<input type="checkbox"/> B	Hearing: Total deafness or inability to hear a normal conversation and/or use a telephone without the aid of an assistive device.	<input type="checkbox"/> N	Digestive Disorders: Periodic stomach or intestinal impairment.
<input type="checkbox"/> C	Speech: Speech impairment which causes speech to be unintelligible in normal conversation.	<input type="checkbox"/> O	Colostomies and Ileostomies: Opening from the digestive tract through the abdominal wall.
<input type="checkbox"/> D	Orthopedic impairments, amputation, or functional limitation of upper or lower extremities, trunk, back or spine.	<input type="checkbox"/> P	Kidney Disease: Must be treated by dialysis.
<input type="checkbox"/> H	Epilepsy: Periodic disturbance of consciousness during which generalized or partial seizure may occur whether medically controlled or not. (Onset may have occurred after the age of 18.)	<input type="checkbox"/> Q	Diabetes: Insulin taken for control.
<input type="checkbox"/> I	Neurological Impairments: Limitation in balance, coordination, sensory and/or cognitive functions, i.e., cerebral palsy, autism.	<input type="checkbox"/> R	History of Cancer: Past or present condition.
<input type="checkbox"/> J	Mental Retardation: When identified by a physician, school system, Department of Rehabilitation, or other responsible agency.	<input type="checkbox"/> S	Conditions of the Skin: Existence of offensive scarring, painful or excessive inflammation or decrease in healthy or normal function.
<input type="checkbox"/> K	Heart or Circulatory Condition: Impairment which substantially interferes with normal work activity.	<input type="checkbox"/> T	Dyslexia: Difficulty in reading caused by transposition of letters or words.
<input type="checkbox"/> L	Disease of the blood and blood forming organs: Disabilities such as leukemia and sickle cell anemia.	<input type="checkbox"/> U	Mental Disorders: When diagnosed by a physician or licensed clinical psychologist.
		<input type="checkbox"/> V	Alcoholism or Drug Addiction: Past impairment which substantially interfered with work activity.
		<input type="checkbox"/> W	Other: Disability not shown on questionnaire.
		<input type="checkbox"/> X	No disability.

NOTE: This form is not to be duplicated after completion by employee.

11 February 1987

APPENDIX T (continued)

State of California

**Memorandum**

To : State Employees

Date : January 31, 1986

From : State Personnel Board -- Affirmative Action and Merit Oversight Division

Subject : Disability Survey

The State Personnel Board is committed to the pursuit of equal employment opportunities for everyone, including the disabled.

Under the Rehabilitation Act of 1973 and California Government Code Section 19233, the State Personnel Board is required to provide employees with the opportunity to self-identify their disability. The data will be used in the production of reports designed to identify areas where discrimination may occur. The reports generated from this information will not identify employees individually and the information will not be reviewed by a medical officer. The data will be incorporated into the State Controller's Office Employment History Data Base. Every effort will be made to ensure the confidentiality of the information provided.

The information being requested on this self-identification is voluntary. The exceptions are special programs where the employee is receiving certain benefits (i.e., COD/Rehab, Limited Examination Appointment Program, Injured State Worker Assistance Program and Provision of Reasonable Accommodation). In these situations, the employee is required to identify any disabling condition which qualifies them for these special considerations.

Before completing the survey on the reverse side, please read the instructions carefully, then enter your social security number where indicated in the upper right corner. This information is needed to process data for statistical summaries and will not be used for any other purpose. Locate the appropriate code letter and record it in the upper right corner following "Disability Code". Please note that a code of "X" indicates no disability. Finally, seal the questionnaire separately in the attached envelope and return it with appointment documents.

If you wish at some future time to change your status, contact your personnel office for the necessary form and instructions on how to initiate a change.

If you have any questions, contact the Affirmative Action for the Disabled Unit at (916) 445-5453, ATSS 485-5453, or TTD 343-0499.

  
LAURA M. AGUILERA, Chief  
Affirmative Action and  
Merit Oversight Division

11 February 1987

CAL ARNGR 690-3  
CA ANGR 40-03

APPENDIX U



Membership Division, Section 840  
400 P Street  
P.O. Box 942704  
Sacramento, CA 94229-2704

Personnel Office  
Please provide a copy of this material only to eligible new members.  
  
Eligible members are listed on page one of the following package.

ACKNOWLEDGEMENT OF RECEIPT OF RETIREMENT INFORMATION

Employee Name \_\_\_\_\_ Social Security No. \_\_\_\_\_  
Please Print

PERS Membership Date \_\_\_\_\_ State \_\_\_\_\_  
Department \_\_\_\_\_

I received the 17-page information and election form package regarding the First-Tier and Second-Tier Retirement Plans (Forms 42A, 42B, 42C).

\_\_\_\_\_  
Signed Date

THIS FORM IS TO BE COMPLETED,  
SIGNED AND LEFT WITH YOUR  
PERSONNEL OFFICE WHICH WILL SEND IT TO PERS

Information Election Package was given to the above employee on \_\_\_\_\_ (Date)  
by \_\_\_\_\_, \_\_\_\_\_ (Public Telephone No.)  
(Personnel Office Staff)

PERS-MEM-42 (A,B,C)  
(9/1/86)

California Public Employees' Retirement System  
Lincoln Plaza-400 P Street-Sacramento, CA

11 February 1987

APPENDIX U (continued)

INFORMATION PRACTICES STATEMENT

The Information Practices Act of 1977 and the Federal Privacy Act require the Public Employees' Retirement System to provide the following information to individuals who are asked to supply information. The information requested is collected pursuant to the Government Code (Sections 20000, et seq.) and will be used for administration of the Board's duties under the Retirement Law, the Social Security Act, and the Public Employees' Medical and Hospital Care Act, as the case may be. Submission of the requested information is mandatory. Failure to supply the information may result in the System being unable to perform its functions regarding your status. Portions of this information may be transferred to: State and public agency employers, California State Attorney General, Office of the State Controller, Teale Data Center, Franchise Tax Board, Internal Revenue Service, Workers' Compensation Appeals Board, State Compensation Insurance Fund, County District Attorneys, Social Security Administration, beneficiaries of deceased members, physicians, insurance carriers, and various vendors who prepare the microfiche/microfilm for PERS. Disclosure to the aforementioned entities is done in strict accordance with current statutes regarding confidentiality.

You have the right to review your membership files maintained by the System. For questions concerning your rights under the Information Practices Act of 1977, please contact the Information Coordinator, PERS, 400 P Street, P.O. Box 942702, Sacramento, CA 94229-2702, (916) 326-3007.

PERS-MEM-42 (A,B,C)  
(9/1/86)

11 February 1987

CAL ARNGR 690-3  
CA ANGR 40-03

APPENDIX V

SEPARATION/DISPOSITION OF P.E.R.S. CONTRIBUTIONS

PERSONNEL OFFICE USE

PLEASE USE BALLPOINT PEN AND PRINT CLEARLY  
THIS IS CARBONLESS PAPER  
RETURN COMPLETED FORM TO YOUR PERSONNEL OFFICE

01 AGENCY	02 UNIT	03 ADD'L IDENTIFICATION
A		

PRINT CLEARLY

01 SOCIAL SECURITY NUMBER	02 EMPLOYEE LAST NAME	03 FIRST NAME AND MIDDLE INITIAL

ENTER SEPARATION DATE AND INDICATE TYPE OF SEPARATION (Check One)

01 DATE OF SEPARATION	02 <input type="checkbox"/> RESIGNATION	<i>This resignation is executed by me freely and voluntarily and of my own free will and is not given by reason of any threat, force, duress, or any undue influence by any person. (Sign in Section F.)</i>	03 <input type="checkbox"/> SEPARATION WITHOUT FAULT BY DEPARTMENT OR CAMPUS
MO DAY YR	04 ENTER REASON FOR RESIGNATION		04 <input type="checkbox"/> OTHER

PUBLIC EMPLOYEES' RETIREMENT SYSTEM MEMBER IF YOU ARE RETIRING, DO NOT COMPLETE THIS SECTION.

CHECK ONE BOX ONLY NOTE: BEFORE COMPLETING, READ SECTION A ON THE REVERSE SIDE OF EMPLOYEE COPY.

**D**

I ELECT TO TERMINATE MY MEMBERSHIP IN P.E.R.S. AND RECEIVE A REFUND OF MY TOTAL ACCUMULATED CONTRIBUTIONS WITH FEDERAL INCOME TAX WITHHELD.

I ELECT TO TERMINATE MY MEMBERSHIP IN P.E.R.S. AND RECEIVE A REFUND OF MY TOTAL CONTRIBUTIONS WITH NO FEDERAL INCOME TAX WITHHELD.  
To be eligible to elect a refund you must be permanently separating from all employment covered by P.E.R.S. If you have less than 3 years service credit with P.E.R.S. and you are permanently separating a refund is mandatory (except as explained in options # 3 and # 4 below). NOTE: Refunds only include interest through the preceding June 30th (Government Code Section 20031).

I ELECT TO CONTINUE MY MEMBERSHIP IN P.E.R.S. AND LEAVE MY TOTAL ACCUMULATED CONTRIBUTIONS ON DEPOSIT BECAUSE:

My service credit with P.E.R.S. equals or exceeds five years.

My separation from employment covered by P.E.R.S. is temporary (less than one year). \_\_\_\_\_  
Enter name of new P.E.R.S. employer if known

I am accepting employment with the following California public agency under the conditions of reciprocity as explained in Section C on the reverse side of employer copy; or I am accepting employment in which I will be a member of the following public retirement system as explained in Section D on the reverse side of employer copy.  
Please enter name of retirement system, city, county, University of California or other:  
\_\_\_\_\_

\*Be sure to notify P.E.R.S. of any future address changes to ensure delivery of your Annual Member Statement.

PRINT CLEARLY YOUR WAGE AND TAX STATEMENT (W-2) AND ANY FINAL WARRANTS AND/OR RETIREMENT REFUND WILL BE MAILED TO THE ADDRESS ENTERED BELOW.

01 EMPLOYEE ADDRESS (STREET, RURAL ROUTE OR P.O. BOX)	02 CITY AND STATE	03 ZIP CODE

EMPLOYEE SIGNATURE

**F** I certify that the above information is true and correct.

X \_\_\_\_\_  
EMPLOYEE SIGNATURE

\_\_\_\_\_  
DATE

PERSONNEL OFFICE USE

**G**

EMPLOYEE UNAVAILABLE for completion of Section D because:  
The employee has been advised that he/she must request the disposition of his/her retirement contributions in writing directly from P.E.R.S.

**01**  LATEST DATE OF CONTRIBUTIONS

**02** Enter the last date P.E.R.S. contributions were or will be deducted from employee's pay. See instructions in PAM or CSU PIMS Manual.

MO DAY YR \_\_\_\_\_ DATE PHONE \_\_\_\_\_

11 February 1987

CAL ARNGR 690-3  
CA ANGR 40-03

APPENDIX W

Employee Clearance Form

NAME	POSITION NUMBER	EFFECTIVE DATE OF CLEARANCE
TYPE OF ACTION		
_____ Transfer	_____ Separation	_____ Leave of Absence

Listed below are items that must be cleared prior to the release of final payment to the employee. It is the responsibility of the supervisor to discuss this with the employee, complete the form, and route it to State Personnel with the separation document.

COMPTROLLER	SUPERVISOR
<b>ADVANCES:</b> _____ Salary _____ Travel _____ Accounts Receivable	<b>MANUALS/PUBLICATIONS:</b> _____ Dictionary _____ Other _____
<b>CREDIT CARDS:</b> _____ Airline _____ Car Charge Card _____ Gasoline _____ Telephone _____ Other _____	<b>EQUIPMENT:</b> _____ Badge _____ Armory Equipment _____ Tape Recorder _____ Keys, Locks _____ Other _____
I certify that records indicate there are no outstanding advances or accounts receivables and that all credit cards have been surrendered.	<b>SECURITY DEBRIEFING:</b> _____ Acknowledged  I have reviewed the records and have determined the above individual is cleared of all state property issued.
COMPTROLLER'S OFFICE SIGNATURE      DATE	SUPERVISOR'S SIGNATURE      DATE

REMARKS:

OTAG Form 900-28 (Revised Jan 87) CAL ARNGR 600-1/690-3, CA ANGR 36-10/40-03 All prior forms are obsolete

11 February 1987

CAL ARNGR 690-3  
CA ANGR 40-03

APPENDIX X



Page 16  
(9/1/86)

ELECTION OF THE FIRST-TIER RETIREMENT PLAN  
PERS-MEM-42C  
September 1, 1986  
Refer to Section 840

Dear Member:

Please complete this form and forward it to PERS within 120 days of your effective date of membership.

A. DECLARATION

I declare that I have read the information on the First-Tier and Second-Tier plans which accompanies this ballot. I understand that this election applies to my service as a state industrial and state miscellaneous member.

B. ELECTION CHOICE

I hereby elect to:

BECOME A MEMBER SUBJECT TO THE FIRST-TIER RETIREMENT PLAN FOR STATE INDUSTRIAL AND QUALIFYING STATE MISCELLANEOUS SERVICE FROM MY EFFECTIVE DATE OF MEMBERSHIP. I understand that I will pay retirement contributions each pay period. At retirement, I will receive benefits based on the First-Tier retirement plan. I also understand that I will be given the opportunity to elect coverage under the Second-Tier during annual open periods.

C. MEMBER'S SIGNATURE

I, \_\_\_\_\_, hereby make the election  
(Signature) indicated in Item B above.

Printed Name: \_\_\_\_\_  
(First Name) (MI) (Last Name)

Date: \_\_\_\_\_ SS#: \_\_\_\_\_

FAILURE TO FILE THIS FORM WITH PERS WITHIN 120 DAYS OF YOUR EFFECTIVE DATE OF MEMBERSHIP WILL BE DEEMED AN IRREVOCABLE ELECTION TO BE SUBJECT TO THE SECOND-TIER RETIREMENT PLAN FOR ALL FUTURE STATE INDUSTRIAL AND QUALIFYING STATE MISCELLANEOUS SERVICE.

Mail to: Public Employees' Retirement System  
P.O. Box 942704  
Sacramento, CA 94229-2704

California Public Employees' Retirement System  
Lincoln Plaza-400 P Street-Sacramento, CA

11 February 1987

APPENDIX X (continued)

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(9/1/86)

INFORMATION PRACTICES STATEMENT

The Information Practices Act of 1977 and the Federal Privacy Act require the Public Employees' Retirement System to provide the following information to individuals who are asked to supply information. The information requested is collected pursuant to the Government Code Sections (20000, et seq.) and will be used for administration of the Board's duties under the Retirement Law, the Social Security Act, and the Public Employees' Medical and Hospital Care Act, as the case may be. Submission of the requested information is mandatory. Failure to supply the information may result in the System being unable to perform its functions regarding your status. Portions of this information may be transferred to: State and public agency employers, California State Attorney General, Office of the State Controller, Teale Data Center, Franchise Tax Board, Internal Revenue Service, Workers' Compensation Appeals Board, State Compensation Insurance Fund, County District Attorneys, Social Security Administration, beneficiaries of deceased members, physicians, insurance carriers, and various vendors who prepare the microfiche/microfilm for PERS. Disclosure to the aforementioned entities is done in strict accordance with current statutes regarding confidentiality.

You have the right to review your membership files maintained by the System. For questions concerning your rights under the Information Practices Act of 1977, please contact the Information Coordinator, PERS, 400 P Street, P.O. Box 942702, Sacramento, CA 94229-2702, (916) 326-3007.

PERS-MEM-42C

11 February 1987

CAL ARNGR 690-3  
CA ANGR 40-03

APPENDIX Y

PINK—PHYSICIAN'S COPY

CANARY—SUPERVISOR'S COPY

STD 620 (REV 12-74)		STATE OF CALIFORNIA SUPERVISOR'S INJURY PREVENTION REPORT		EMPLOYEE WORK INJURY		Date of Report	
<b>A. INJURED EMPLOYEE</b>			<b>B. MEDICAL TREATMENT</b>			<b>C. SUPERVISOR</b>	
Date of Injury		Time		First Aid Given By:			Name of Supervisor
Last Name		First Middle		<input type="checkbox"/> Treated Self			Department
Home Address			Treated by (physician)			Division	
City or Town			Office Address			Supervisor's Office Mailing Address	
Home Telephone Number			Telephone Number			Office Telephone Number	
Civil Service Classification			Hospital			Signature	
Place Injury Occurred (address)							
<b>SUPERVISOR'S COMMENTS:</b> (Use other side for more information, sketches, etc.)							
1. Describe nature of injury and part of body affected as employee tells about it:							
2a. Facts available lead me to believe this work injury was caused by and happened during State work.		<input type="checkbox"/>		2b. From the facts I need my superior's or a physician's advice. The alleged claim of injury is not clearly identified with State employment.		<input type="checkbox"/>	
2c. The facts do not indicate this claim of injury was work connected.		<input type="checkbox"/>				<input type="checkbox"/>	
3. Give the facts that justify the items checked.							
4. Did injury result in disability beyond day of accident? <input type="checkbox"/> YES <input type="checkbox"/> NO If "YES," give date last worked.							
5. What was injured during at time of injury? (Explain so people at your headquarters will understand)							
6. Describe work place and conditions which contributed to the accident—also what safety devices were in use?							
7. Fully explain sequence of events that resulted in injury (how did employee's actions and work conditions combined, cause injury?)							
8. What steps are necessary to prevent recurrence of a similar injury?				8a. Have you taken these steps? <input type="checkbox"/> YES <input type="checkbox"/> NO If "NO," explain.			
9. Witnesses' names:							

SI 00143

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APPENDIX Y (continued)

REVIEWING OFFICER

9. Did you follow the steps of accident?

YES NO If "NO," explain.

10. Did you talk to the injured employee?

YES NO If "NO," explain.

11. Prior to accident, what direct supervision was given to injured? (Job instructions, planning, equipment safety, service, inspection, etc.)

12. What actions of employee or working conditions caused this accident? (Give reasons for causes selected.)

13. Suggest on corrective action taken, also what has been done about any contributing causes.

Signature Title Date

14. For injuries requiring medical services from physicians, or disability beyond day of injury—promptly request Form 67, Employee's Request for Services, and File at State Compensation Insurance Fund. If supervisor checked No 1b or 1c, indicating questionable liability, a copy of this report and appropriate supplemental memo attached to be forwarded to State Compensation Insurance Fund.

SUPERVISOR'S COMMENTS: For more information, sketches, etc.

APPENDIX Z (continued)

State of California  
EMPLOYER'S REPORT  
OF OCCUPATIONAL  
INJURY OR ILLNESS

SEND TWO SIGNED COPIES TO  
STATE COMPENSATION INSURANCE FUND  
Refer to STATE ADMINISTRATIVE MANUAL, SECTIONS 2581.2-2581.5  
for instructions on completion and routing.  
BOTH SIDES OF THIS FORM MUST BE COMPLETED

OSHA Case  
or File No.

California law requires an employer to report within five days every industrial injury or occupational disease which: (a) Results in lost time beyond the day of injury, or (b) requires medical treatment other than first aid. PLEASE NOTE: In addition, if death results or if the injury or illness: (a) Requires inpatient hospitalization of more than 24 hours for other than medical observation, or (b) results in loss of any member of the body; or (c) produces any serious degree of permanent disfigurement, then the nearest district office of the California Division of Occupational Safety and Health also must be notified immediately by telephone or telegraph. This notification is not required, however, if the injury or death results from an accident on a public street or highway.  
FILING OF THIS REPORT IS NOT AN ADMISSION OF LIABILITY

STATE AGENCY	1 DEPARTMENT		DIVISION		PLEASE DO NOT USE THIS COLUMN	
	2 BUREAU		3 PAYROLL AGENCY CODE OR SCIF POLICY NO			
	3 MAILING ADDRESS (PLEASE INCLUDE CITY AND ZIP)			PHONE		
	4 LOCATION (IF DIFFERENT FROM MAILING ADDRESS)			5 STATE UNEMPLOYMENT INSURANCE ACCT NUMBER NONE		
EMPLOYEE	6 NAME		7 DATE OF BIRTH Month / Day / Year		INDUSTRY	
	8 HOME ADDRESS (Number and street city Zip)		8A PHONE NUMBER		OCCUPATION	
	9 SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	10 OCCUPATION (Regular job title not specific activity at time of injury)		11 SOCIAL SECURITY NUMBER		SEX
	12 DEPARTMENT IN WHICH REGULARLY EMPLOYED			12A DATE OF HIRE Month / Day / Year		AGE
	13 HOURS USUALLY WORKED EMPLOYEE WORKS _____ HOURS PER DAY FOR _____ DAYS PER WEEK		13A WEEKLY HOURS		13B Under what class code of job policy were wages assigned?	
	14 GROSS WAGES SALARY EMPLOYEE EARNS \$ _____ PER <input type="checkbox"/> HOUR <input type="checkbox"/> DAY <input type="checkbox"/> WEEK <input type="checkbox"/> EVERY TWO WEEKS <input type="checkbox"/> MONTH <input type="checkbox"/> OTHER		15A COUNTY		15B ON EMPLOYER'S PREMISES <input type="checkbox"/> YES <input type="checkbox"/> NO	
	15 WHERE DID ACCIDENT OR EXPOSURE OCCUR? (Number and street city)		15A COUNTY		15B ON EMPLOYER'S PREMISES <input type="checkbox"/> YES <input type="checkbox"/> NO	
	16 WHAT WAS EMPLOYEE DOING WHEN INJURED? Please be specific. Identify tools, equipment or material the employee was using.					APPEARANCE
	17 HOW DID THE ACCIDENT OR EXPOSURE OCCUR? Please describe fully the events that resulted in injury or occupational disease. Tell what happened and how it happened. Please use separate sheet if necessary.					APPEARANCE
	18 OBJECT OR SUBSTANCE THAT DIRECTLY INJURED EMPLOYEE e.g. the machine employee struck against or which struck him; the vapor or poison inhaled or swallowed; the chemical that irritated his skin; in cases of strains, the thing he was lifting, pulling, etc.					NATURE OF INJURY
19A DESCRIBE THE INJURY OR ILLNESS e.g. cut, strain, fracture, skin rash, etc.			19B PART OF BODY AFFECTED e.g. back, left wrist, right eye, etc.			
20 NAME AND ADDRESS OF PHYSICIAN (include phone number)					SOURCE	
21 HOSPITALIZED NAME AND ADDRESS OF HOSPITAL					APPEARANCE	
22 DATE OF INJURY OR ILLNESS Month / Day / Year		23 TIME OF DAY _____ a.m. _____ p.m.		24 Did employee lose at least one full day's work after the injury? <input type="checkbox"/> Yes date lost worked _____ <input type="checkbox"/> No		
25 HAS EMPLOYEE RETURNED TO WORK? <input type="checkbox"/> Yes date returned _____ <input type="checkbox"/> No still off work			26 DID EMPLOYEE DIE? <input type="checkbox"/> Yes date _____ <input type="checkbox"/> No			
27 WAS ANOTHER PERSON RESPONSIBLE FOR THE INJURY? <input type="checkbox"/> YES <input type="checkbox"/> NO			28 PERS STRS MEMBER <input type="checkbox"/> YES <input type="checkbox"/> NO LEAVE CREDIT ACCUMULATION <input type="checkbox"/> YES <input type="checkbox"/> NO ARE LEAVE CREDITS AVAILABLE TO BE USED IN SUPPLEMENTING TEMPORARY DISABILITY BENEFITS? <input type="checkbox"/> YES <input type="checkbox"/> NO			
29 HAVE YOU GIVEN THE INJURED EMPLOYEE WRITTEN NOTICE OF WORKERS COMPENSATION BENEFITS WITHIN 5 WORKING DAYS OF YOUR KNOWLEDGE OF THE INJURY? <input type="checkbox"/> YES <input type="checkbox"/> NO					CODED BY	
Completed by (type or print)		Signature		Title		
				Date		

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APPENDIX Z (continued)

If the Supervisor and Manager Review portions of this form cannot be completed within five days of the injury, DO NOT DELAY SUBMISSION OF THE REVERSE SIDE TO STATE FUND. Submit the form completed in its entirety to the Departmental Safety Coordinator within ten days of the injury.

EMPLOYEE'S NAME	UNIT	SOCIAL SECURITY NUMBER
<b>SUPERVISOR'S REVIEW</b>		
Facts available lead me to believe this work injury was caused by and happened during State work. <input type="checkbox"/>	From the facts I need my superior's or a physician's advice. The alleged claim of injury is not clearly identified with State employment. <input type="checkbox"/>	The facts do not indicate this claim of injury was work connected. <input type="checkbox"/>
GIVE THE FACTS THAT JUSTIFY THE ITEMS CHECKED.		
WHAT CORRECTIVE ACTION IS BEING TAKEN TO PREVENT SIMILAR ACCIDENTS? HAVE YOU TAKEN THESE STEPS? YES <input type="checkbox"/> NO <input type="checkbox"/> If no, explain		
I DO NOT HAVE AUTHORITY TO TAKE THE FOLLOWING ACTION BUT RECOMMEND:		
IF INJURED EMPLOYEE IS UNABLE TO PERFORM FULL DUTY: A THE POSSIBILITY OF MODIFIED WORK WAS DISCUSSED WITH THE ATTENDING DOCTOR: <input type="checkbox"/> YES <input type="checkbox"/> NO B MODIFIED WORK DECISION: <input type="checkbox"/> Condition precludes M.W. <input type="checkbox"/> Appropriate M.W. not available <input type="checkbox"/> M.W. arranged (days)		
Signature	Classification	Date
<b>MANAGER'S REVIEW</b>		
DO YOU CONCUR WITH 1ST LINE SUPERVISOR'S REVIEW? <input type="checkbox"/> YES <input type="checkbox"/> NO If no, explain		
Signature and Date		

CONTINUATION AND MISCELLANEOUS COMMENTS:

STATE COMPENSATION INSURANCE FUND ADJUSTING OFFICES

P.O. BOX 915  
ARCADIA, CA 91006-0915

P.O. BOX 9729  
BAKERSFIELD, CA 93389-9729

P.O. BOX 6165  
CERRITOS, CA 90701-1384

P.O. BOX 2518  
CULVER CITY, CA 90231-2518

P.O. BOX 4420  
EUREKA, CA 95502-4420

P.O. BOX 40000  
FRESNO, CA 93755-4001

P.O. BOX 2134, TERMINAL ANNEX  
LOS ANGELES, CA 90051-0134

P.O. BOX 12971  
OAKLAND, CA 94604-2971

P.O. BOX 2377  
REDDING, CA 96099-2377

P.O. BOX 254700  
SACRAMENTO, CA 95865-4700

P.O. BOX 1316  
SAN BERNARDINO, CA 92402-1316

P.O. BOX 85488  
SAN DIEGO, CA 92138-0488

P.O. BOX 807  
SAN FRANCISCO, CA 94101-0807

P.O. BOX 759  
SAN JOSE, CA 95106-0759

P.O. BOX 419  
SANTA ANA, CA 92702-0419

P.O. BOX 2407  
SANTA ROSA, CA 95405-0407

P.O. BOX 8000  
STOCKTON, CA 95208-0018

P.O. BOX 5  
VENTURA, CA 93002-2258

P.O. BOX 1950  
WOODLAND HILLS, CA 91365-1950

11 February 1987

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APPENDIX AA

**DOCTOR'S CERTIFICATE**  
Medical Records or I.D. No. \_\_\_\_\_

*Certification may be made by a licensed physician and surgeon, osteopath, chiropractor, dentist, podiatrist, optometrist, designated psychologist, an authorized medical officer of a United States Government facility or an accredited religious practitioner. ALL ITEMS MUST BE COMPLETED.*

12 I attended the patient for the present medical problem from: Month Day Year Month Day Year At intervals of \_\_\_\_\_ TO \_\_\_\_\_

13 History (State nature, severity and bodily extent of the incapacitating disease or injury.) \_\_\_\_\_

Findings \_\_\_\_\_

Diagnosis \_\_\_\_\_  
Confirmed by X-ray or other tests? YES  NO

14 Is, or has the patient been pregnant since the date of treatment reported above?  
If "YES," give date pregnancy terminated or future EDC: \_\_\_\_\_ YES  NO   
Is the pregnancy normal? YES  NO  If "NO," state nature and severity of maternal disability: \_\_\_\_\_

15 Operation  
Performed  Type of Operation: \_\_\_\_\_  
To be performed  (Enter date) \_\_\_\_\_

16 Has this patient at any time during your attendance been incapable of performing his or her regular work? YES  NO  If "YES," the disability commenced on: \_\_\_\_\_

17 Approximate date, in your opinion, disability (if any) should end or has ended sufficiently to permit the patient to resume regular or customary work. Even if considerable question exists, make some estimate. This is a requirement of the Code, and the claim will be delayed if such date is not entered. Such answers as "indefinite" or "don't know" will not suffice. (Enter date) \_\_\_\_\_

18 In your opinion, is this disability the result of "occupation" either as an "industrial accident" or as an occupational disease? (This should include aggravation of pre-existing conditions by occupation.) YES  NO

19 Have you reported this or a concurrent disability to any insurance carrier as an Industrial Disability Leave or Workers' Compensation claim? If "YES," give name of carrier or firm: YES  NO

20 Further comments (if indicated): \_\_\_\_\_

21 In what HOSPITAL was or is patient confined as a registered bed patient? Hospital name and address: \_\_\_\_\_

22 Date entered as a registered bed patient? \_\_\_\_\_ Date discharged \_\_\_\_\_ ZIP Code \_\_\_\_\_

23 Would the disclosure of this information to your patient be medically or psychologically detrimental to the patient? YES  NO

I hereby certify that the above statements in my opinion truly describe the patient's disability (if any) and the estimated duration thereof, and that I am a \_\_\_\_\_ licensed to practice by the State of \_\_\_\_\_  
Type of doctor \_\_\_\_\_  
Print or type doctor's name \_\_\_\_\_ Signature of attending doctor \_\_\_\_\_

No. and Street \_\_\_\_\_ City \_\_\_\_\_ ZIP Code \_\_\_\_\_ State License No. \_\_\_\_\_ Telephone No. \_\_\_\_\_ Date form signed \_\_\_\_\_

MAIL COMPLETED FORM TO: State of California, Employment Development Department  
P.O. Box 13140  
Sacramento, CA 95813

APPENDIX AA (continued)

STATE OF CALIFORNIA **NONINDUSTRIAL DISABILITY INSURANCE** CLAIM STATEMENT

**ATTENDANCE CLERK - PAYROLL OFFICER**

POSITION NUMBER: AGENCY UNIT CLASS SERIAL

SOCIAL SECURITY ACCOUNT NUMBER

Please complete this part before giving or sending the form to the employee.

NAME OF EMPLOYEE: First Initial Last SEX (M  F )

Vacation leave rate: \_\_\_\_\_ Last day physically worked? \_\_\_\_\_

Full-time employee? YES  NO  If "NO", did EE have 6 monthly compensated PP's in the 18 PP's immediately preceding disability? YES  NO

Perm./Prob. employee? YES  NO  PERS/STRS member? YES  NO  Exempt employee? YES  NO

Name and address of Personnel Transactions Unit or Section responsible for employee's payroll documents: \_\_\_\_\_

Did period of employment ending on the above date exceed 14 calendar days? YES  NO

Department or Campus: \_\_\_\_\_

Did employee leave work because of sickness or injury? YES  NO

PTU or Section: \_\_\_\_\_

If "NO", please give reason: \_\_\_\_\_

Street address: \_\_\_\_\_

P.O. Box, City and ZIP Code: \_\_\_\_\_

If employee has returned to work, enter date(s) returned: \_\_\_\_\_

Completed by: \_\_\_\_\_

Employee's leave balances at COB as of last day worked: Sick Leave \_\_\_\_\_ Hrs. Vacation \_\_\_\_\_ Hrs.

Other leave credits employee elected to use: \_\_\_\_\_ Hrs.

Leave credits to be paid through \_\_\_\_\_ Date \_\_\_\_\_ Hrs. (if less than 8)

ATSS No. (area code) \_\_\_\_\_ Other (area code) \_\_\_\_\_

**EMPLOYEE COMPLETE ALL ITEMS BELOW AFTER YOU HAVE STOPPED WORKING DUE TO DISABILITY**

1. Your mailing address: Street, P.O. Box, or R.F.D. Apt. No. City State ZIP Code 2. Year of birth \_\_\_\_\_

Home address: (If different from mailing address) \_\_\_\_\_

4. Type of work: \_\_\_\_\_

3. What was the first full day you were too sick to work even if it was a Saturday, Sunday, holiday or normal day off? Month Day Year \_\_\_\_\_

5. What was the last day you worked before this disability? Month Day Year \_\_\_\_\_

6. Did you work more than 14 days during your last period of employment which ended on the date shown in item (3) above? YES  NO

7. Did you stop work because of sickness or injury? If "NO," please explain. YES  NO

8. Was this disability caused by your work? If "YES," please explain. YES  NO

Are you claiming or receiving Workers' Compensation or Industrial Disability Leave for any on-the-job injuries or illnesses during the period covered by this claim? YES  NO

9. IF YOU ARE STILL DISABLED AFTER YOU EXHAUST YOUR SICK LEAVE, WILL YOU ELECT TO RECEIVE YOUR ACCRUED VACATION PAY? YES  NO

10. Have you recovered or returned to work for any day, part time or full time, after the date shown in item (3) above? If "YES," please enter such dates. YES  NO

11. I hereby claim benefits and certify that for the period covered by this claim I was unemployed and disabled, that the foregoing statements and any accompanying statements are to the best of my knowledge and belief true, correct and complete. I hereby authorize my attending physician, practitioner or hospital to furnish and disclose all facts concerning my disability that are within their knowledge, and to allow inspection of and provide copies of any hospital records concerning my disability that are under their control.

Date Claim Signed: \_\_\_\_\_ Your Signature (Do Not Print): \_\_\_\_\_ Your Phone Number: \_\_\_\_\_ (area code)

**IT IS A MISDEMEANOR TO WILFULLY MAKE A FALSE STATEMENT OR TO KNOWINGLY CONCEAL A MATERIAL FACT IN ORDER TO OBTAIN THE PAYMENT OF ANY BENEFITS.**

If your signature is made by mark (X) it must be attested by two witnesses with their addresses.

Signature \_\_\_\_\_ Address \_\_\_\_\_

Signature \_\_\_\_\_ Address \_\_\_\_\_

11 February 1987

CAL ARNGR 690-3  
CA ANGR 40-03

APPENDIX BB

STATE OF CALIFORNIA

EMPLOYEE NAME	SOCIAL SECURITY NUMBER	UNIT TELEPHONE NO
---------------	------------------------	-------------------

UNEMPLOYMENT INSURANCE CLAIM RECORD

UNIT, POSITION, AND SERIAL NUMBER	DATE LAST WORKED
-----------------------------------	------------------

REASON - CHECK ONE

LACK OF WORK       MAXIMUM 1500 HOURS WORKED       END OF TEMPORARY APPOINTMENT

OTHER - EXPLAIN \_\_\_\_\_

I CONCUR WITH THE REASON CHECKED ABOVE

SIGNATURE OF EMPLOYEE	DATE
-----------------------	------

STO 600 (8/82)

11 February 1987

CAL ARNGR 690-3  
CA ANGR 40-03

APPENDIX CC

STATE OF CALIFORNIA

**UNEMPLOYMENT COMPENSATION NOTICE**

SD 650 (NEW 11/82)

This form has been given to you because (1) you have been separated from your job, or (2) you were placed in a nonpay status.

When unemployed, State workers may be entitled to Unemployment Insurance (UI) benefits similar to those of workers in private industry. If you become unemployed or are in a nonpay status and want to FILE A CLAIM, go to the nearest LOCAL OFFICE of the EMPLOYMENT DEVELOPMENT DEPARTMENT to register for work and file your claim for UI. Your ELIGIBILITY FOR UI CANNOT be determined until AFTER you file a claim. DO NOT DELAY filing a UI claim; if you wait, your unemployment benefits may be reduced or you may not qualify for any benefits.

**TAKE WITH YOU—**

1. Your SOCIAL SECURITY ACCOUNT NUMBER CARD. (If you do not have a card, apply for one, but you do not need to delay filing your claim pending its receipt.)
2. THIS FORM and all similar forms which you have received. The office where you file your claim will obtain information needed for your claim from:

State agency will insert in the box above the name of the State agency address and ZIP Code of the specific office that should receive notice of your claim as required by law.

**KEEP THIS FORM with your other personnel records. It is important to have it if you file a UI claim. For more information about UI, read the REVERSE side of this form.**

APPENDIX CC (continued)

**Information: UI For State Workers**

1. Who will pay unemployment benefits?

If you are eligible, you will be paid by the Employment Development Department (EDD) under the provisions of California Unemployment Insurance Code. The amount of your regular weekly benefits and the period for which benefits will be paid will be determined by EDD based on the wages you were paid during one year period beginning 16-18 months before the date your claim is filed. (If you have received all the regular benefits for which you are eligible, you may, under certain circumstances, become eligible for additional weeks of extended benefits.)

UI for unemployed State workers is paid from State funds. No deductions were taken from your pay to finance these benefits.

2. Under what conditions will I be eligible?

- a. You must be unemployed or working less than full time, able to work and available for any suitable work;
- b. You must register for work and file a claim at a local public employment service/UI claim office;  
You must continue to report to the office as directed; and
- c. You must have had a certain amount of employment/wages within a base period of 1 year specified in the law.

You may be denied benefits for such reasons as:

- a. Quitting your job voluntarily without good cause or being discharged for misconduct connected with your work; or
- b. Refusing an offer of a suitable job without good cause.

3. Do I have the right of appeal?

- a. Yes. If a determination is made denying you benefits, you have the right to appeal. You or the employer have 20 calendar days to appeal in writing after written notice is given.

4. Are there any penalties?

- a. Yes. If you willfully make a false (fraudulent) claim, you may be fined or imprisoned, or both. If you made a mistake in giving information when you filed your claim(s), notify the local UI claims office as soon as you discover the mistake; prompt notification may avoid a penalty.

(The above statements are issued for general information; they do not have the effect of law, regulation, or ruling.)

11 February 1987

CAL ARNGR 690-3  
CA ANGR 40-03

APPENDIX DD

STATE OF CALIFORNIA  
**ABSENCE AND ADDITIONAL  
TIME WORKED REPORT**  
STD 634 (10/85)

PAY PERIOD			TIME BASE	WWG	CB-ID
1 MONTH	YEAR	SEMI-MONTHLY STATUS ONLY			
		<input type="checkbox"/> FIRST HALF <input type="checkbox"/> SECOND HALF			
2. NAME (First, Middle, Last)		3. SOCIAL SECURITY NUMBER	4. POSITION NUMBER		

5. ABSENCE WITH PAY		6. ABSENCE WITHOUT PAY		7. DATES OF ABSENCE AND EXTRA TIME WORKED	
(1) <input type="checkbox"/> SICK LEAVE SELF	(10) <input type="checkbox"/> SICK LEAVE FAMILY ILLNESS	(11) <input type="checkbox"/> SICK LEAVE DEATH IN FAMILY (RELATIONSHIP)	(12) <input type="checkbox"/> VACATION	(13) <input type="checkbox"/> SICK LEAVE	(14) <input type="checkbox"/> SICK LEAVE
(15) <input type="checkbox"/> SICK LEAVE SELF	(16) <input type="checkbox"/> SICK LEAVE FAMILY ILLNESS	(17) <input type="checkbox"/> SICK LEAVE DEATH IN FAMILY (RELATIONSHIP)	(18) <input type="checkbox"/> VACATION	(19) <input type="checkbox"/> SICK LEAVE	(20) <input type="checkbox"/> SICK LEAVE
(21) <input type="checkbox"/> SICK LEAVE SELF	(22) <input type="checkbox"/> SICK LEAVE FAMILY ILLNESS	(23) <input type="checkbox"/> SICK LEAVE DEATH IN FAMILY (RELATIONSHIP)	(24) <input type="checkbox"/> VACATION	(25) <input type="checkbox"/> SICK LEAVE	(26) <input type="checkbox"/> SICK LEAVE
(27) <input type="checkbox"/> SICK LEAVE SELF	(28) <input type="checkbox"/> SICK LEAVE FAMILY ILLNESS	(29) <input type="checkbox"/> SICK LEAVE DEATH IN FAMILY (RELATIONSHIP)	(30) <input type="checkbox"/> VACATION	(31) <input type="checkbox"/> SICK LEAVE	(32) <input type="checkbox"/> SICK LEAVE

(33) <input type="checkbox"/> SICK LEAVE SELF	(34) <input type="checkbox"/> SICK LEAVE FAMILY ILLNESS	(35) <input type="checkbox"/> SICK LEAVE DEATH IN FAMILY (RELATIONSHIP)	(36) <input type="checkbox"/> VACATION	(37) <input type="checkbox"/> SICK LEAVE	(38) <input type="checkbox"/> SICK LEAVE
(39) <input type="checkbox"/> SICK LEAVE SELF	(40) <input type="checkbox"/> SICK LEAVE FAMILY ILLNESS	(41) <input type="checkbox"/> SICK LEAVE DEATH IN FAMILY (RELATIONSHIP)	(42) <input type="checkbox"/> VACATION	(43) <input type="checkbox"/> SICK LEAVE	(44) <input type="checkbox"/> SICK LEAVE
(45) <input type="checkbox"/> SICK LEAVE SELF	(46) <input type="checkbox"/> SICK LEAVE FAMILY ILLNESS	(47) <input type="checkbox"/> SICK LEAVE DEATH IN FAMILY (RELATIONSHIP)	(48) <input type="checkbox"/> VACATION	(49) <input type="checkbox"/> SICK LEAVE	(50) <input type="checkbox"/> SICK LEAVE

REPORTING	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	TOTAL	
7A. HOURS WORKED (NET TO BE PAID)																																	
7B. SICK																																	
7C. SICK LEAVE																																	
7D. VACATION																																	
7E. YES, NO, YES, PM, & M, NO, J																																	
7F. L OR A																																	
7G. STRAIGHT TIME (NO. OF HRS.)																																	
7H. PREMIUMS (NO. OF HRS.)																																	

8. REASON FOR ABSENCE OR EXTRA HOURS WORKED  MEDICAL APPOINTMENT  DENTAL APPOINTMENT

9. CERTIFICATE BY EMPLOYEE  
To the best of my knowledge and belief, the facts stated are accurate and in full compliance with legal requirements.

EMPLOYEE SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

10. RECOMMENDATION AND SUBSTANTIATION OF SUPERVISOR

APPROVAL RECOMMENDED  APPROVAL NOT RECOMMENDED

SUBSTANTIATION SHALL BE REQUIRED FOR SICK LEAVE OF MORE THAN TWO CONSECUTIVE WORK DAYS. SHOW METHOD OF VERIFICATION BELOW.

11. STATEMENT BY PHYSICIAN (Not to be completed by attending physician for industrial illness or injury.)

DOCTOR STATEMENT ATTACHED

AS PHYSICIAN, I EXAMINED AND TREATED OR PRESCRIBED FOR THIS PATIENT ON THESE DATES

DATE OF RETURN TO WORK \_\_\_\_\_ IF STILL DISABLED, GIVE ESTIMATE DATE OF RETURN TO WORK \_\_\_\_\_

THE ILLNESS OR INJURY CAUSING THE DISABILITY WAS \_\_\_\_\_

SIGNATURE OF SUPERVISOR \_\_\_\_\_ DATE \_\_\_\_\_

SIGNATURE OF ATTENDING PHYSICIAN \_\_\_\_\_ DATE \_\_\_\_\_

12. PERIOD ON DISABILITY COMPENSATION FROM _____ TO _____	13. DISABILITY COMPENSATION SUPPLEMENT		14. OFFICIAL DEPARTMENTAL ACTION		REVIEWED BY _____	
	HOURS	SICK LEAVE	VACATION	OTD	HOLIDAY CREDIT	<input type="checkbox"/> APPROVED _____
						<input type="checkbox"/> DISAPPROVED _____

APPENDIX DD (continued)

INSTRUCTIONS

GENERAL INFORMATION

1. All absences or additional hours worked by full-time or part-time employees should be reported on one Form Std. 634 for each pay period. Report all time worked for permanent intermittent and part-time employees.

2. Prepare the number of copies required by our department. Employees who want a copy for their own records, indicating supervisor's signature, may prepare an extra copy.

INSTRUCTIONS FOR FILLING OUT FORM STD. 634 BY ITEM NUMBER (see reverse side)

1. Enter pay period, month and year and complete other boxes as required by your department.

2-4. Complete name, social security number and position number.

5. Absences With Pay—Check appropriate box, indicating type(s) of absence(s). Furnish all information requested in items requiring additional information. Attach Military Duty orders if applicable.

6. Absences Without Pay (Ded.)—Complete all boxes, indicating type of unpaid absence and if the current pay period is qualified or nonqualified. Last box can be checked if employee is serving a probationary period to determine if employee will complete required number of working days.

Qualifying Pay Period—Eleven (11) or more paid days in a monthly pay period.

Nonqualifying Pay Period—Less than eleven (11) paid days in a monthly pay period.

Note: If the employee is absent without pay for more than eleven (11) consecutive working days, which falls between two (2) consecutive otherwise qualifying pay periods, one (1) pay period shall be disqualifying.

7. Dates of Absence and Extra Hours Worked

7a. Enter time to be paid for each day, including paid absence hours for intermittent or part-time employees.

Note: Enter all hours to be paid in the total column.

7b. Indicate sick leave hours and appropriate symbol on date of absence.

Sick Leave shall be used in increments of one (1) hour and is shown on the appropriate date with a symbol "S" or "SS". If more than two (2) hours is needed for a doctor's appointment, the reason should be stated in item 8. Enter the letter symbol and the number of hours under the number(s) corresponding to the dates being reported.

Sick Family—Provisions for family sick are outlined by the memorandum of understanding between your exclusive representative and the State of California.

7c. Bereavement Leave—Provisions for bereavement leave are outlined by the memorandum of understanding between your exclusive representative and the State of California.

Sick Death—Employees in bargaining units which did not negotiate bereavement leave provisions may use up to five (5) days of their sick leave balance for each family member.

7d. Vacation shall be used in increments of one (1) hour and is shown on the appropriate date with the symbol "V".

An absence can be charged against vacation credits only when approved by the appointing power. The time at which vacation shall be taken may be specified to suit the convenience of the department. Vacation cannot be taken as an absolute right unless the appointing power does not provide a vacation for the employee for two successive years.

7e. Post proper symbol and number of hours for type of absence being reported.

Paid Educational Leave—Following completion of twelve (12) qualifying pay periods of continuous service, a full-time employee in State civil service employed in a position requiring teaching certification qualification shall be allowed fifteen (15) days credit or educational leave with pay. Thereafter, on the first (1st) of the pay period following each additional qualifying pay period of service, he/she shall be allowed one and one-fourth (1-1/4) days credit for educational leave with pay. The employee may earn or use educational leave credit only while in a position requiring teacher certification qualifications. The granting of paid educational leave is at the discretion of the appointing power.

Military Leave—Attach a copy of any applicable military order. Every calendar day must be recorded, including any Saturday, Sunday or holiday.

Jury Duty or Subpoenaed Witness—An employee may be absent with pay for time actually served to perform jury duty or for time subpoenaed as a witness in a court case when the employee is neither a party nor an expert witness, providing the employee remits the fee to the State. If the fee is retained, either a charge is made against the employee's accumulated leave balance or absence is without pay. It is up to the employee to demand of the party requesting their appearance a subpoena and whatever fees and travel allowance that may be allowed by law. Witness fees for a civil trial are governed by Government Code Sections 68093-68096 and the fee for a criminal trial is governed by Penal Code Section 1329. The employee may keep travel allowance.

7f. Post proper symbol and number of hours for type of absence reporting, enter an approved absence without pay (dock) or an unapproved absence without pay (AWOL).

An Unapproved Absence Without Pay—Can be for any amount of time up to five (5) working days. If the AWOL exceeds five (5) consecutive working days, this constitutes an automatic resignation from State service.

7g. Enter symbols and hours to be compensated at straight time as indicated below:

- WO — Overtime hours worked for CTO
- P — Overtime hours worked for pay
- HC — (CSUC only) Hours worked on a holiday
- WE — Excess hours worked due to irregular work shift

7h. Enter symbols and hours to be compensated at premium time as indicated below (Personnel Office will convert to time and one-half (1-1/2)).

- WO — Overtime hours worked for CTO
- P — Overtime hours worked for pay

Note: Total column may be used for items 7b through 7g.

8. Reason for Absence or Extra Hours Worked—Employee must indicate reason for sick leave absences, including relationship of family member when reporting family sick leave.

Note: This item also can be used for reporting reasons for overtime hours worked or for unpaid absences.

9. Employee's Responsibility and Signature—Employees have the responsibility to give their supervisor advance notification when they anticipate a future absence. When unanticipated emergency causes the absence, the employees are responsible for notifying supervisor as soon as possible and keeping their supervisor informed as to the possible date of return. Employees are also responsible for promptly reviewing and signing their absence report at the end of the pay period and submitting to supervisor.

10. Recommendation of Supervisor's Responsibility—Each supervisor is responsible for seeing that employees comply with the regulations governing absence from work. The supervisor is expected to recommend against approval of sick leave absences when satisfactory evidence as to need is not presented. Supervisor is then responsible for promptly reviewing and signing the employee's absence report and forwarding it to the Personnel Office.

Before recommending approval for sick leave by an INTERMITTENT EMPLOYEE, supervisor shall certify that the employee was scheduled to work during the hours reported for sick leave.

Note: Methods of verification can include telephone, physician statement, home or hospital visit.

11. Statements By Physicians—If physician statement is attached, check first box and do not complete other information in this item.

If supervisor has requested the physician's verification on this form, second box is checked and the doctor completes each item and signs the form.

12- Applicable information regarding absences due to industrial injury or illness should be recorded in this area.

14. Completed by Personnel Office only.

11 February 1987

CAL ANGR 690-3  
CA ANGR 40-03

APPENDIX EE

STATE OF CALIFORNIA

REPORT OF PERFORMANCE  
FOR PROBATIONARY EMPLOYEE

STD 636 (REV. 5/84)

FIRST  
 SECOND  
 FINAL

NAME LAST	FIRST	INITIAL	SOCIAL SECURITY NUMBER	DATE OF REPORT
CIVIL SERVICE TITLE			POSITION NUMBER	DATE PROBATION ENDS
STATE DEPARTMENT		SUBDIVISION OF DEPARTMENT		HEADQUARTERS OF EMPLOYEE

YOUR WORK PERFORMANCE WILL DETERMINE WHETHER YOU OBTAIN PERMANENT CIVIL SERVICE STATUS.

QUALIFICATION FACTORS	RATINGS ARE INDICATED BY "X" MARKS			
	UNACCEPTABLE	IMPROVEMENT NEEDED	STANDARD	OUTSTANDING
1. SKILL - EXPERTNESS IN DOING SPECIFIC TASKS; ACCURACY; PRECISION; COMPLETENESS; NEATNESS; QUANTITY.				
2. KNOWLEDGE - EXTENT OF KNOWLEDGE OF METHODS, MATERIALS, TOOLS, EQUIPMENT, TECHNICAL EXPRESSIONS AND OTHER FUNDAMENTAL OBJECT MATTER.				
3. WORK HABITS - ORGANIZATION OF WORK; CARE OF EQUIPMENT; PUNCTUALITY AND DEPENDABILITY; INDUSTRY; FOLLOWS GOOD PRACTICES OF VEHICLE AND PERSONAL SAFETY.				
4. RELATIONSHIPS WITH PEOPLE - ABILITY TO GET ALONG WITH OTHERS; EFFECTIVENESS IN DEALING WITH THE PUBLIC; OTHER EMPLOYEES, PATIENTS OR INMATES.				
5. LEARNING ABILITY - SPEED AND THOROUGHNESS IN LEARNING PROCEDURES, LAWS, RULES AND OTHER DETAILS; ALERTNESS; PERSEVERANCE.				
6. ATTITUDE - ENTHUSIASM FOR THE WORK; WILLINGNESS TO CONFORM TO JOB REQUIREMENTS AND TO ACCEPT SUGGESTIONS FOR WORK IMPROVEMENT, ADAPTABILITY.				
7. ABILITY AS SUPERVISOR - PROFICIENCY IN TRAINING EMPLOYEES AND PLANNING, ORGANIZING, ASSIGNING AND GETTING OUT WORK; LEADERSHIP; UNDERSTANDING OF AND EFFECTIVENESS IN IMPLEMENTING DEPARTMENTAL AND SPB PERSONNEL MANAGEMENT POLICIES INCLUDING EQUAL EMPLOYMENT OPPORTUNITY AND AFFIRMATIVE ACTION.				
8. ADMINISTRATIVE ABILITY - PROMPTNESS OF ACTION; SOUNDNESS OF DECISION; APPLICATION OF GOOD MANAGEMENT PRACTICES; UNDERSTANDING AND EFFECTIVE IMPLEMENTATION OF DEPARTMENTAL AND SPB PERSONNEL MANAGEMENT POLICIES INCLUDING EQUAL EMPLOYMENT OPPORTUNITY AND AFFIRMATIVE ACTION.				
9. FACTORS NOT LISTED ABOVE (USE ADDITIONAL SHEETS IF MORE SPACE IS NEEDED)				
OVER-ALL RATING - THE OVER-ALL RATING MUST BE CONSISTENT WITH THE FACTOR RATINGS AND COMMENTS, BUT THERE IS NO PRESCRIBED FORMULA FOR COMPUTING THE OVER-ALL RATING.				

COMMENTS TO EMPLOYEE (SUPERVISOR SHOULD INCLUDE FACTUAL EXAMPLES ON WORK ESPECIALLY WELL OR POORLY DONE AND GIVE SUGGESTIONS AS TO HOW PERFORMANCE CAN BE IMPROVED. FACTOR AND OVER-ALL RATINGS OF UNACCEPTABLE AND OVER-ALL RATINGS OF OUTSTANDING MUST BE SUBSTANTIATED. USE ADDITIONAL SHEETS IF MORE SPACE IS NEEDED.)

RATER DISCUSSED REPORT WITH EMPLOYEE.  YES  NO

I RECOMMEND YOU BE GRANTED PERMANENT CIVIL SERVICE STATUS.  
(To be checked only on Final Report. If the probationer is rejected, notification must be given as prescribed by Government Code Section 19173.)

YES  NO

SIGNATURE OF RATER	TITLE	DATE
IN SIGNING THIS REPORT I DO NOT NECESSARILY AGREE WITH THE CONCLUSIONS OF THE RATER		<input type="checkbox"/> I WOULD LIKE TO DISCUSS THIS REPORT WITH THE REVIEWING OFFICER
SIGNATURE OF EMPLOYEE	DATE	
I CONCUR IN THE RATINGS GIVEN BY THE RATER. I HAVE MADE NO CHANGE IN THIS REPORT		AS REQUESTED, REVIEWING OFFICER DISCUSSED REPORT WITH EMPLOYEE ON
SIGNATURE OF REVIEWING OFFICER	DATE	DATE INITIALS

DISTRIBUTION Copies: 1—Departmental Files 2—Employee 3—Supervisor 4—Miscellaneous

11 February 1987

CAL ARNGR 690-3  
CA ANGR 40-03

APPENDIX FF

STATE OF CALIFORNIA

INDIVIDUAL DEVELOPMENT PLAN  
FOR FUTURE JOB PERFORMANCE OF PERMANENT EMPLOYEES  
STD. 427 (10/76)

EMPLOYEE'S NAME (LAST, FIRST, MIDDLE INITIAL)		DATE OF THIS PERFORMANCE DISCUSSION	
CIVIL SERVICE TITLE	POSITION NUMBER	DATE OF LAST PERFORMANCE DISCUSSION	
STATE DEPARTMENT	SUBDIVISION OF DEPARTMENT	EMPLOYEE'S HEADQUARTERS	

PERFORMANCE OBJECTIVES - Goals for further improvements in job performance during the next year in order to meet or exceed standards for the employee's present job or to develop employee skills.

PLANS FOR ACHIEVING OBJECTIVES - Specific methods by which the employee can work toward accomplishing his or her performance objectives (in-service training courses, college courses, rotation, special work assignments for training purposes, etc.).

I HAVE PARTICIPATED IN A DISCUSSION OF OVER-ALL JOB PERFORMANCE

SIGNATURE OF EMPLOYEE	DATE	SIGNATURE OF SUPERVISOR	DATE
-----------------------	------	-------------------------	------

(Over)

11 February 1987

APPENDIX FF (continued)

PERFORMANCE APPRAISAL SUMMARY  
 OF PAST JOB PERFORMANCE OF PERMANENT EMPLOYEES  
 STD. 637 (1/78) - REVERSE

PERFORMANCE FACTORS	I	M	E	COMMENTS*
1. <b>QUALITY OF WORK:</b> Consider the extent to which completed work is accurate, neat, well-organized, thorough, and effective.				
2. <b>QUANTITY OF WORK:</b> Consider the extent to which the amount of work produced compares to quantity standards for the job.				
3. <b>WORK HABITS:</b> Consider the employee's effectiveness in organizing and using work tools and time, in caring for equipment and materials, in following good practices of vehicle and personal safety, etc.				
4. <b>RELATIONSHIPS WITH PEOPLE:</b> Consider the extent to which the employee recognizes the needs and desires of other people, treats others with respect and courtesy, inspires their respect and confidence, etc.				
5. <b>TAKING ACTION INDEPENDENTLY:</b> Consider the extent to which the employee shows initiative in making work improvements, identifying and correcting errors, initiating work activities, etc.				
6. <b>MEETING WORK COMMITMENTS:</b> Consider the extent to which employee completes work assignments, meets deadlines, follows established policies and procedures, etc.				
7. <b>ANALYZING SITUATIONS AND MATERIALS:</b> Consider the extent to which the employee applies consistently good judgment in analyzing work situations and materials, and in drawing sound conclusions.				
8. <b>SUPERVISING THE WORK OF OTHERS:</b> Consider the employee's effectiveness in planning and controlling work activities, motivating and developing subordinates, improving work methods and results, encouraging and supporting employee suggestions for work improvements, applying policies, selecting and developing subordinates in accordance with State Personnel Board and departmental affirmative action policies.				
9. <b>PERSONNEL MANAGEMENT PRACTICES:</b> Consider the extent to which the employee understands and applies good personnel management practices including affirmative action and upward mobility. Does the employee contribute effectively to the implementation of State Personnel Board and departmental equal employment opportunity policies and to the attainment of affirmative action goals?				

GENERAL COMMENTS OR COMMENTS ON OTHER FACTORS

\*The supervisor may make "Comments" only, or may use rating categories only, or may use either or both methods of appraisal on any performance factor, as he/she prefers. The rating categories are:  
 I. Improvement needed for performance to meet expected standards.  
 M. Performance fully meets expected standards.  
 E. Performance consistently exceeds expected standards.



APPENDIX GG (continued)

**Section 599.859. GRIEVANCE AND APPEAL PROCEDURE.**

(a) The purpose of grievance and appeal procedures is to provide for the prompt review and resolution of issues either formally or informally at the lowest possible level.

(b) Definitions.

(1) "Grievance". A grievance is a dispute of one or more employees involving the application or interpretation of a statute, regulation, policy or practice which falls under the jurisdiction of the department.

(2) "Non-Merit Statutory Appeal". A non-merit, statutory appeal is: an appeal of transfer in accordance with Government Code sections 19994.2-19994.4; a petition to set aside resignation in accordance with Government Code section 19996.1; an appeal for reinstatement after automatic resignation (AWOL) in accordance with Government Code section 19996.2; or an appeal of layoff in accordance with Government Code section 19997.14.

(c) Grievance Procedures.

Each appointing power may establish in writing a procedure for the resolution of grievances of its employees and any such procedure shall be subject to the review and approval by the Department. However unless such a procedure is established, the appointing power shall follow the standard grievance procedure prescribed by the Department in Subsection (d).

(d) Standard Grievance Procedure. Each party involved in a grievance shall attempt to resolve the grievance promptly. Every effort should be made to complete required actions within the time limits contained in the grievance procedure. However, with the mutual consent of the parties, the time limit for any step may be extended.

(1) A grievance procedure shall consist of as few levels of review as practicable; however, no procedure shall provide for more than four levels of review.

(2) Informal Discussion. The employee or the employee's representative shall discuss the grievance with the employee's immediate supervisor. If the grievance is not settled within five (5) work days, a written grievance may be filed.

(3) Formal Grievance — Level 1. A formal grievance may be filed no later than ten (10) work days after the event or circumstances occasioning the grievance. The first level of review shall respond to the grievance in writing within ten (10) work days after the receipt of the formal grievance.

(4) Formal Grievance — Level 2. The grievant may appeal the decision of the first level within ten (10) work days after receipt of the response. Within fifteen (15) work days after receipt of the appealed grievance, the person designated by the department head as the second level of review shall respond in writing to the grievance.

(5) Formal Grievance — Level 3. The grievant may appeal the decision of the second level within ten (10) work days after receipt of the response to the department head or his/her designee. Within fifteen (15) work days after receipt of the appeal, the department head or his/her designee shall respond in writing to the grievance.

(6) Formal Grievance — Level 4. The grievant may appeal the decision of the third level within ten (10) work days after receipt of the response to the Director of the Department of Personnel Administration or his/her designee. Within twenty (20) work days the Director of the Department of Personnel Administration or his/her designee shall respond in writing to the grievance.

(e) Forms.

The Department shall prescribe a standard supervisory and excluded employee grievance form and any additional forms to be used in processing grievances.

(f) Representation.

The employee and representative, recognized by the Department in accordance with the provisions of Section 599.857, may be authorized a reasonable amount of work time, as determined by the appointing power and approved by the Department, to prepare and present a grievance.

(g) Non-Merit Statutory Appeals.

(1) Disputes regarding appeals of layoff, appeals of transfer, petitions to set aside resignation, appeals for reinstatement after automatic resignation shall be filed in writing directly with the Director. Such appeals shall be filed in accordance with specific time limits prescribed by applicable statute.

(2) Such appeal may be assigned to a hearing officer for hearing or investigation. The hearing officer is the authorized representative of the Director and is fully authorized and empowered to grant or refuse extensions of time, to set such proceeding for hearing, to conduct a hearing or investigation in every such proceeding, and to perform any and all other acts in connection with such proceeding that may be authorized by law or by this article.

(3) Rehearing.

Within thirty (30) days after service of a copy of the decision any party may file a written petition for rehearing with the Director. Within thirty (30) days after such filing, the Director shall serve a copy of the petition upon the other parties to the proceeding. Within sixty (60) days after service of the petition for rehearing, the Director shall either grant or deny the petition in whole or in part. Failure to act upon a petition for rehearing within the ninety (90) day period is a denial of the petition. If a rehearing is granted, the Director may rehear the case itself on all the pertinent parts of the record of the prior hearing and such additional evidence and argument as may be permitted by the Director.

(4) Decision Becomes Final When.

Unless a proper application for rehearing is made in accordance with subsection (g)(3), every decision shall become final 30 days after service by the Department of a copy of such decision upon the parties to the proceeding in which the decision is rendered.

Note: Authority cited: Sections 3522.9, 3532, 19915.4(d) Government Code.

Reference: Sections 3522.9(f), 3532(f), 18714, 19994.4, 19996.1, 19996.2, 19997.14 Government Code.



11 February 1987

APPENDIX HH (continued)

STD 430 (NEW 10/82)

DATE RECEIVED		DATE OF RESPONSE	GRIEVANCE REVIEW—LEVEL I	
			LEVEL I DECISION TO BE ENTERED BELOW	

SIGNATURE OF LEVEL I REVIEWER		PRINTED NAME AND TITLE		TELEPHONE NUMBER
<input type="checkbox"/> I CONCUR AND DO NOT APPEAL TO THE SECOND REVIEW LEVEL REASON FOR APPEAL		<input type="checkbox"/> I DO NOT CONCUR AND APPEAL TO THE SECOND REVIEW LEVEL (IF CHECKED, STATE REASON BELOW)		GRIEVANT'S SIGNATURE DATE

DATE RECEIVED		DATE OF RESPONSE	GRIEVANCE REVIEW—LEVEL II	
			<input type="checkbox"/> DECISION ATTACHED	
SIGNATURE OF LEVEL II REVIEWER		PRINTED NAME AND TITLE		
<input type="checkbox"/> I CONCUR AND DO NOT APPEAL TO THE THIRD REVIEW LEVEL REASON FOR APPEAL		<input type="checkbox"/> I DO NOT CONCUR AND APPEAL TO THE THIRD REVIEW LEVEL (IF CHECKED, STATE REASON BELOW)		GRIEVANT'S SIGNATURE DATE

DATE RECEIVED		DATE OF RESPONSE	GRIEVANCE REVIEW—LEVEL III—DEPARTMENT DIRECTOR OF DESIGNEE	
			<input type="checkbox"/> DECISION ATTACHED	
SIGNATURE OF DIRECTOR OR DESIGNEE		PRINTED NAME AND TITLE		
<input type="checkbox"/> I CONCUR AND DO NOT APPEAL TO THE FOURTH REVIEW LEVEL REASON FOR APPEAL		<input type="checkbox"/> I DO NOT CONCUR AND APPEAL TO THE FOURTH REVIEW LEVEL (IF CHECKED, STATE REASON BELOW)		GRIEVANT'S SIGNATURE DATE

DATE RECEIVED		DATE OF RESPONSE	GRIEVANCE REVIEW—LEVEL IV—DEPARTMENT OF PERSONNEL ADMINISTRATION	
			<input type="checkbox"/> DECISION ATTACHED	
SIGNATURE OF DIRECTOR OR DESIGNEE		PRINTED NAME AND TITLE		

11 February 1987

CAL ARNGR 690-3  
CA ANGR 40-03

APPENDIX II

SUPERIOR ACCOMPLISHMENT AWARD RECOMMENDATION

TO  
MERIT AWARD BOARD

In accordance with the provision of Section 13926 of the Government Code, Article 14 of Rules and Regulations of the State Board of Control, and procedures set forth in Sections 4780 through 4783 of the State Administrative Manual, it is recommended that award consideration be given for the Superior Accomplishment herein described, which has been performed by the following named employee of this department:

NAME	POSITION TITLE
------	----------------

DESCRIPTION OF ACCOMPLISHMENT (Give specific facts, using the outline on the reverse side and the State Administrative Manual as a guide. Attach additional sheet if necessary)

BASED UPON THE ABOVE FACTS I RECOMMEND THAT YOUR BOARD CONSIDER GRANTING AN AWARD OF

SIGNATURE (DEPARTMENT HEAD)	TITLE
DEPARTMENT	DATE

11 February 1987

## APPENDIX II (continued)

### Guide for Preparing Superior Accomplishment Recommendation

- I State, in narrative, which of the following for which the award is recommended:
  - A. An act of superior job performance resulting in an exceptional contribution to the efficiency of State Government, sustained over a period of not less than 24 months.
  - B. An act of non-recurring nature, which may include, but is not limited to:
    1. An outstanding and superior achievement of a non-recurring nature. (State why the same problem will not arise again in the foreseeable future.)
    2. An important contribution to science or research.
    3. An unequalled personal effort in overcoming unusual difficulties or obstacles.
    4. The completion of an assigned task in a significantly shorter period of time than was deemed possible.
    5. A major improvement in methods, organization, procedures, or products (which make an exceptional contribution to the efficiency or economy of the State Government or an exceptional improvement in its operations).
- II Describe the specific achievement in detail.
- III Describe specifically how the achievement is clearly and unquestionably above normal requirements of the employee's position. (The degree to which it exceeds standards of performance.)
- IV Describe the degree the accomplishment necessitated the employee expend personal effort beyond that normally expected. (Relationship of the personal effort to his normal work.)
- V Describe the amount and nature of ingenuity, initiative and creative effort displayed. (Method used when standard methods would have produced unacceptable or average results.)
- VI BENEFITS:
  - A. Describe the tangible or intangible benefits which accrue to the State as a result of the accomplishment.
  - B. If applicable, express tangible aspects comparatively in terms of one or more of the following:
    1. Quantity of acceptable work units per period of time.
    2. Quality standards.
      - a. Accuracy of results
      - b. Effect obtained.
      - c. Physical appearance of product.
    3. Time within which work must be completed.
  - C. To what extent do the benefits extend beyond the immediate organization or department?

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APPENDIX JJ

STATE OF CALIFORNIA - MERIT AWARD BOARD

DO NOT WRITE IN THIS SPACE

EMPLOYEE SUGGESTION

STD 645 (2/79)

Please type or print with pen in black or dark blue ink only - Do not use pencil

NAME OF EMPLOYEE(S) (LAST, FIRST, MIDDLE INITIAL)		DEPARTMENT (INCLUDE ADDRESS OF WORK LOCATION)	CIVIL SERVICE TITLE
<input type="checkbox"/> MISS	RESIDENCE ADDRESS (NO. STREET)	CITY	WORKERS TITLE
<input type="checkbox"/> MRS.			
<input type="checkbox"/> MS.			
<input type="checkbox"/> MR.			
OFFICE PHONE		PUBLIC NO. / AREA NO.	

JOB/TITLE - DESCRIPTION IN A FEW WORDS

IF MORE SPACE NEEDED, ATTACH ADDITIONAL SHEETS

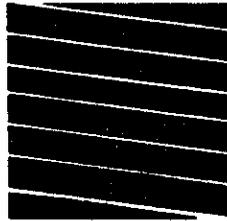
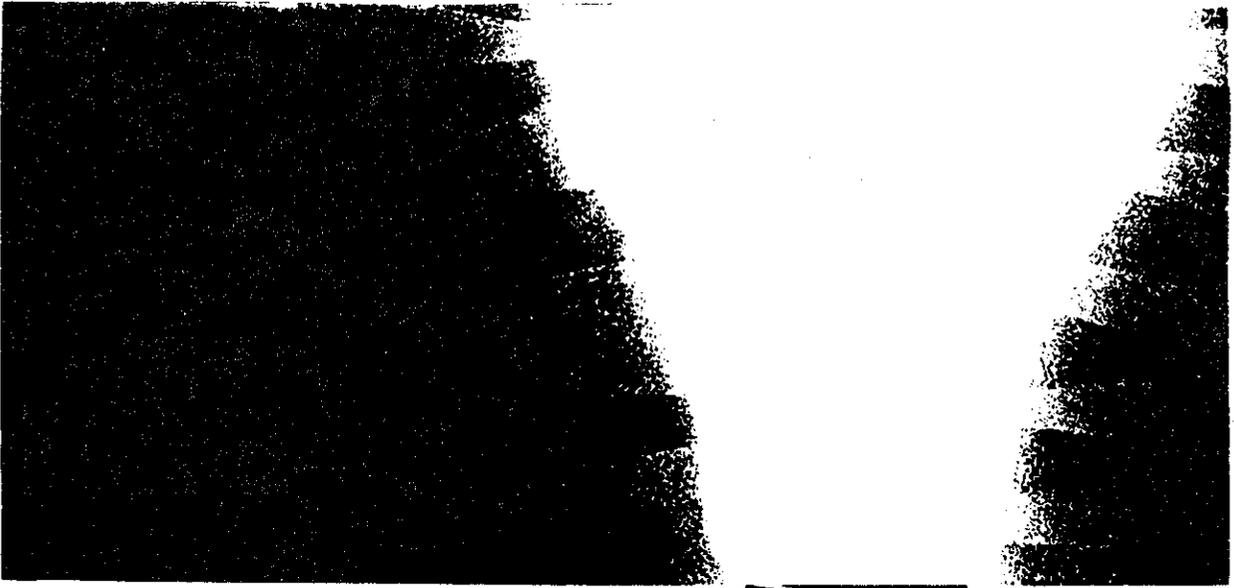
THE WAY IT IS NOW	
THE WAY I SUGGEST IT SHOULD BE	
ADVANTAGES OF MY IDEA	

<input type="checkbox"/> IN CONSIDERING MY SUGGESTION (CHECK ONE) <input type="checkbox"/> YOU MAY DISCLOSE MY NAME <input type="checkbox"/> DO NOT DISCLOSE MY NAME UNLESS SUGGESTION IS ADOPTED	The use by the State of California of my suggestion shall not form the basis of a further claim of any nature upon the State of California by me, my heirs or assigns.	SIGNATURE EACH SUGGESTER (NOT ACCEPTABLE IF UNSIGNED) DATE
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21002-103 125M-05P

11 February 1987

APPENDIX JJ (continued)



AFTER FIVE DAYS RETURN TO

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

U.S. POSTAGE  
OR INTER-  
DEPARTMENTAL  
MAIL

ANOTHER EMPLOYEE  
SUGGESTION TO



Department of Personnel Administration  
Merit Award Board  
1115 11th Street  
Sacramento, CA 95814

CAL ARNGR 690-3  
CA ANGR 40-03

11 February 1987

(CASS)

BY ORDER OF THE GOVERNOR:

OFFICIAL:

WILLARD A. SHANK  
Major General  
The Adjutant General

ANDREW OF CASIA JR.  
COL (CA) FA \* CDR ARNG  
Director of Administration  
DISTRIBUTION  
ARMY  
Air -

