

APPLICATION FOR SUBSTITUTE TEACHER

*An Equal Opportunity Employer**

Date of application _____				
Personal Data	Name _____			
	<i>Last</i>	<i>First</i>	<i>Middle initial</i>	
	Mailing address _____			
	<i>Street/Box</i>	<i>City</i>	<i>State</i>	
	E-mail address _____			
	Home phone _____ Cell phone _____ Other phone _____			
Other name that may appear on records _____				
<i>(Used for certification, reference, and criminal history record checks)</i>				
Are you receiving Teacher Retirement System (TRS) retirement benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Are you employed as a part-time employee by a TRS-covered employer? <input type="checkbox"/> Yes <input type="checkbox"/> No				
(Required to determine if the district will be assessed a monthly surcharge as required by TRS rules.)				
Assignment	Please list the days you are available to substitute and your assignment preferences.			
	Day(s) of week <input type="checkbox"/> Every day			
	<input type="checkbox"/> Monday <input type="checkbox"/> Tuesday <input type="checkbox"/> Wednesday <input type="checkbox"/> Thursday <input type="checkbox"/> Friday			
	Assignment <input type="checkbox"/> Any assignment			
<input type="checkbox"/> Elementary <input type="checkbox"/> Intermediate <input type="checkbox"/> Secondary <input type="checkbox"/> Special Education				
Preferred campuses: _____				

Position Data	Credentials included with application:			
	<input type="checkbox"/> Résumé			
	<input type="checkbox"/> All teaching and professional certificates or licenses			
<input type="checkbox"/> All transcripts showing degrees				
Have you been employed by _____ ISD in the past? <input type="checkbox"/> Yes <input type="checkbox"/> No				
If you answered yes, provide dates of employment _____				
Education/Training	List the highest level of education attained: _____			
	Licenses and certificates granted _____			
	Name and location of schools attended	Course of study and major/minor	Diploma, degree, certificate, or license granted	Year graduated <i>(College only)</i>

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Certification	<p>Certificates or Licenses Currently Held:</p> <p><input type="checkbox"/> None</p> <p><input type="checkbox"/> Valid Texas</p> <p><input type="checkbox"/> Valid Other State _____</p> <p><input type="checkbox"/> Texas One-Year (out-of-state/country): Expiration date: _____</p> <p><input type="checkbox"/> Other: _____</p> <p>Category/Level(s) of Certification: _____</p> <p>Areas of Specialization/Supplemental Certificates/Endorsements (as listed on certification):</p> <p>_____</p> <p>_____</p> <p>_____</p>																																										
Teaching Experience	<p>List teaching experience beginning with most recent years. Attach additional sheets if necessary.</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 25%;">Name and location of school</td> <td style="width: 25%;"></td> <td style="width: 25%;">Name and location of school</td> <td style="width: 25%;"></td> </tr> <tr> <td>Type of assignment</td> <td></td> <td>Type of assignment</td> <td></td> </tr> <tr> <td>Dates taught</td> <td></td> <td>Dates taught</td> <td></td> </tr> <tr> <td>Principal's name and phone</td> <td></td> <td>Principal's name and phone</td> <td></td> </tr> <tr> <td>Reason for leaving</td> <td></td> <td>Reason for leaving</td> <td></td> </tr> <tr> <td>Name and location of school</td> <td></td> <td>Name and location of school</td> <td></td> </tr> <tr> <td>Type of assignment</td> <td></td> <td>Type of assignment</td> <td></td> </tr> <tr> <td>Dates taught</td> <td></td> <td>Dates taught</td> <td></td> </tr> <tr> <td>Principal's name and phone</td> <td></td> <td>Principal's name and phone</td> <td></td> </tr> <tr> <td>Reason for leaving</td> <td></td> <td>Reason for leaving</td> <td></td> </tr> </table>			Name and location of school		Name and location of school		Type of assignment		Type of assignment		Dates taught		Dates taught		Principal's name and phone		Principal's name and phone		Reason for leaving		Reason for leaving		Name and location of school		Name and location of school		Type of assignment		Type of assignment		Dates taught		Dates taught		Principal's name and phone		Principal's name and phone		Reason for leaving		Reason for leaving	
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Other Work Experience	Provide a list of all other jobs or administrative positions you have held in the past 10 years. Attach additional sheets if necessary. Attach résumé if available.			
	Employer name and location		Employer name and location	
	Position/title held		Position/title held	
	Dates employed		Dates employed	
	Supervisor's name and phone		Supervisor's name and phone	
	Reason for leaving		Reason for leaving	
	Employer name and location		Employer name and location	
	Position/title held		Position/title held	
	Dates employed		Dates employed	
	Supervisor's name and phone		Supervisor's name and phone	
	Reason for leaving		Reason for leaving	
	References	List references the district can contact regarding your work history.		
Full name of reference		School district/ firm name	Mailing address	Position/title
				Area code/ phone number

APPLICATION FOR SUBSTITUTE TEACHER

General Information	<p>Have you ever been convicted of, pled guilty or no contest (nolo contendere) to, or received probation, suspension, or deferred adjudication for a felony or any offense involving moral turpitude (including, but not limited to, theft, rape, murder, swindling, and indecency with a minor)? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, please state where, when, and the nature of the offense _____</p> <p>_____</p> <p>_____</p> <p>(A felony conviction is not an automatic bar to employment. The district will consider the nature, date, and relationship between the offense and the position for which you are applying.)</p>
Verification	<p>I hereby affirm that all information provided in this application is true and accurate to the best of my knowledge and understand that any deliberate falsifications, misrepresentations, or omissions of fact may be grounds for rejection of my application or dismissal from subsequent employment.</p> <p>I authorize the references listed on the previous page to give you any and all information concerning my previous employment and any pertinent information they may have, personal or otherwise, and release all such parties from liability for any damage that may result from furnishing the same to you.</p> <p>I understand that the district is required by Texas Education Code to review criminal history record information of substitute teachers.</p> <p>I understand that I am required to report any outside employment with a TRS-covered employer to the district and provide a monthly record of hours worked so the district can determine if it will be subject to the monthly surcharge.</p> <p style="text-align: center;">_____</p> <p style="text-align: center;">Signature Date</p> <p>This application becomes the property of the district. The district reserves the right to accept or reject it.</p>

**Applicants for all positions are considered without regard to race, color, sex (including pregnancy), national origin, religion, age, disability, genetic information, veteran or military status, or any other legally protected status. Additionally, the district does not discriminate against an applicant who acts to oppose such discrimination or participates in the investigation of a complaint related to a discriminating employment practice.*

The district Title IX Coordinator is Gary Speegle, Superintendent, 1414 N Austin, Comanche, TX 76442.

DPS Computerized Criminal History (CCH) Verification

(AGENCY COPY)

I, _____, have been notified that a Computerized Criminal History (CCH) verification check will be performed by accessing the Texas Department of Public Safety Secure Website and will be based on name and DOB identifiers I supply.

Because the name-based information is not an exact search and only fingerprint record searches represent true identification to criminal history, the organization conducting the criminal history check for background screening is not allowed to discuss any criminal history record information obtained using the name and DOB method. Therefore, the agency may request that I have a fingerprint search performed to clear any misidentification based on the result of the name and DOB search.

For the fingerprinting process I will be required to submit a full and complete set of my fingerprints for analysis through the Texas Department of Public Safety AFIS (Automated Fingerprint Identification System). I have been made aware that in order to complete this process I must make an appointment with L1 Enrollment Services, submit a full and complete set of my fingerprints, request a copy be sent to the agency listed below, and pay a fee of \$24.95 to the fingerprinting services company, L1 Enrollment Services.

Once this process is completed and the agency receives the data from DPS, the information on my fingerprint criminal history record may be discussed with me.

(This copy must remain on file by your agency. Required for future DPS Audits)

Signature of Applicant or Employee

Date

Comanche ISD
Agency Name (Please print)

Lisa Warren
Agency Representative Name (Please print)

Signature of Agency Representative

Date

Please: Check and Initial each Applicable Space	
CCH Report Printed:	
YES _____ NO _____	_____ initial
Purpose of CCH: _____	
Hire _____ Not Hired _____	_____ initial
Date Printed: _____	_____ initial
Destroyed Date: _____	_____ initial
Retain in your files	

COMANCHE INDEPENDENT SCHOOL DISTRICT

CRIMINAL HISTORY INFORMATION REQUEST

Confidential*

The Comanche Independent School District is required by Texas Education Code Chapter 22, Subchapter C to review the criminal history of applicants, employees, independent contractors, student teachers, and certain volunteers. The information requested below is necessary to obtain criminal history record information.

Please print.

Name _____
Last First Middle
Social Security Number _____ Date of birth _____

Driver's License _____
State and Number

Mailing Address _____
Street City State Zip

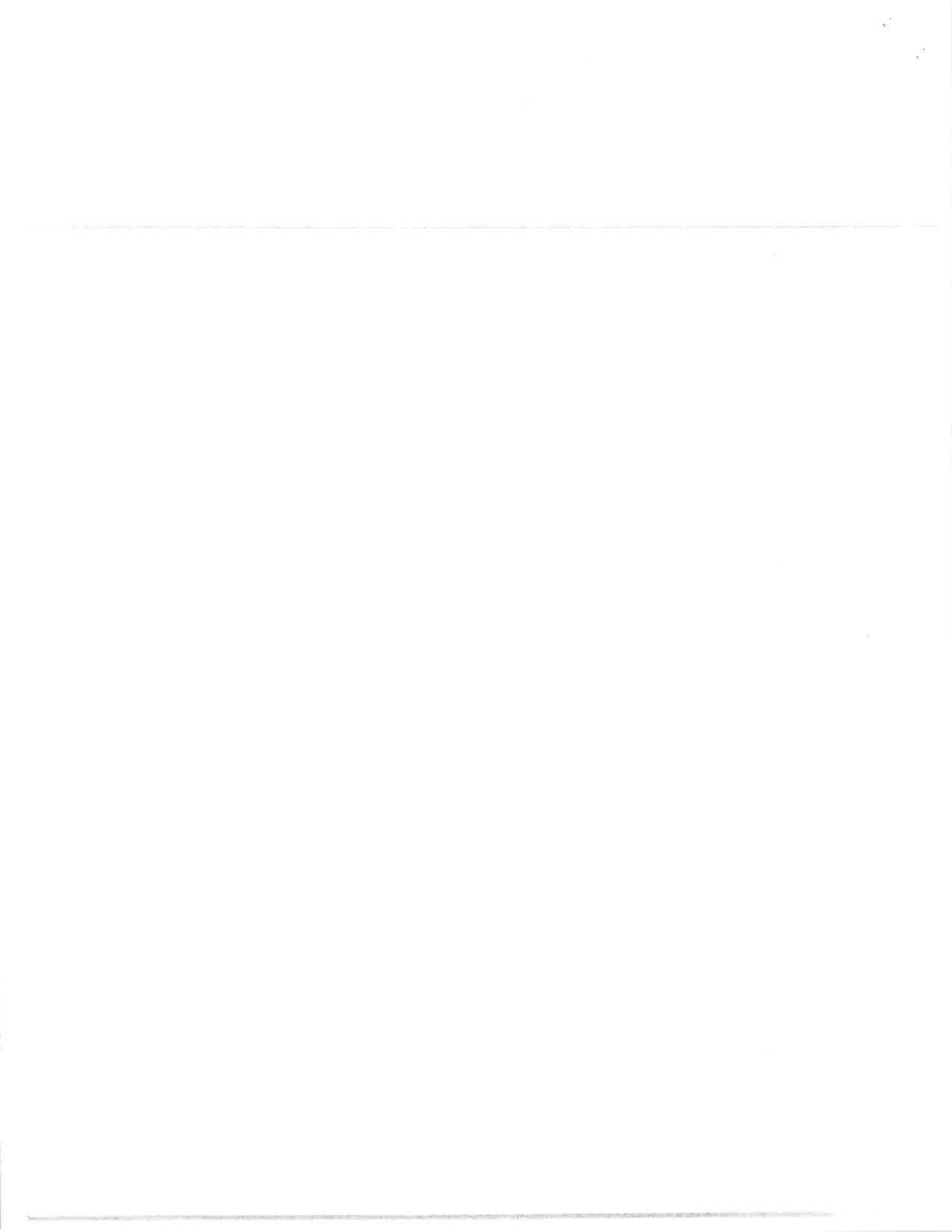
Sex: Male Female Ethnicity: Black White/Other

I understand that the information I am providing about age, sex, and ethnicity will not be used to determine eligibility for employment but will be used *solely* for the purpose of obtaining criminal history record information.

Signature

Date

* This form will be removed from the application and filed separately in the HR office.



Form W-4 (2017)

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

Exemption from withholding. If you are exempt, complete **only** lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2017 expires February 15, 2018. See Pub. 505, Tax Withholding and Estimated Tax.

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

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

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

The exceptions don't apply to supplemental wages greater than \$1,000,000.

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

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

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

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

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

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

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

Check your withholding. After your Form W-4 takes effect, use Pub. 505 to see how the amount you are having withheld compares to your projected total tax for 2017. See Pub. 505, especially if your earnings exceed \$130,000 (Single) or \$180,000 (Married).

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

Personal Allowances Worksheet (Keep for your records.)

A	Enter "1" for yourself if no one else can claim you as a dependent	A	<u> </u>
B	Enter "1" if: { <ul style="list-style-type: none"> • You're single and have only one job; or • You're married, have only one job, and your spouse doesn't work; or • Your wages from a second job or your spouse's wages (or the total of both) are \$1,500 or less. 	B	<u> </u>
C	Enter "1" for your spouse . But, you may choose to enter "-0-" if you are married and have either a working spouse or more than one job. (Entering "-0-" may help you avoid having too little tax withheld.)	C	<u> </u>
D	Enter number of dependents (other than your spouse or yourself) you will claim on your tax return	D	<u> </u>
E	Enter "1" if you will file as head of household on your tax return (see conditions under Head of household above)	E	<u> </u>
F	Enter "1" if you have at least \$2,000 of child or dependent care expenses for which you plan to claim a credit (Note: Do not include child support payments. See Pub. 503, Child and Dependent Care Expenses, for details.)	F	<u> </u>
G	Child Tax Credit (including additional child tax credit). See Pub. 972, Child Tax Credit, for more information. • If your total income will be less than \$70,000 (\$100,000 if married), enter "2" for each eligible child; then less "1" if you have two to four eligible children or less "2" if you have five or more eligible children. • If your total income will be between \$70,000 and \$84,000 (\$100,000 and \$119,000 if married), enter "1" for each eligible child.	G	<u> </u>
H	Add lines A through G and enter total here. (Note: This may be different from the number of exemptions you claim on your tax return.) ▶	H	<u> </u>

For accuracy, complete all worksheets that apply. {

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

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

Form W-4 Department of the Treasury Internal Revenue Service	<h2 style="margin: 0;">Employee's Withholding Allowance Certificate</h2> <p style="margin: 0;">▶ Whether you are entitled to claim a certain number of allowances or exemption from withholding is subject to review by the IRS. Your employer may be required to send a copy of this form to the IRS.</p>	OMB No. 1545-0074 2017
1 Your first name and middle initial Last name		2 Your social security number
Home address (number and street or rural route)		3 <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Married, but withhold at higher Single rate. Note: If married, but legally separated, or spouse is a nonresident alien, check the "Single" box.
City or town, state, and ZIP code		4 If your last name differs from that shown on your social security card, check here. You must call 1-800-772-1213 for a replacement card. ▶ <input type="checkbox"/>
5 Total number of allowances you are claiming (from line H above or from the applicable worksheet on page 2)		5 <u> </u>
6 Additional amount, if any, you want withheld from each paycheck		6 \$ <u> </u>
7 I claim exemption from withholding for 2017, and I certify that I meet both of the following conditions for exemption. • Last year I had a right to a refund of all federal income tax withheld because I had no tax liability, and • This year I expect a refund of all federal income tax withheld because I expect to have no tax liability. If you meet both conditions, write "Exempt" here ▶		7 <u> </u>
Under penalties of perjury, I declare that I have examined this certificate and, to the best of my knowledge and belief, it is true, correct, and complete.		
Employee's signature (This form is not valid unless you sign it.) ▶		Date ▶
8 Employer's name and address (Employer: Complete lines 8 and 10 only if sending to the IRS.)		9 Office code (optional)
		10 Employer identification number (EIN)

COMANCHE INDEPENDENT SCHOOL DISTRICT
Direct Deposit Authorization Agreement

I hereby authorize Comanche ISD to initiate credit entries and to initiate, if necessary, debit entries and adjustments for any credit entries made in error to my account indicated below and the depository named below, hereinafter called DEPOSITORY, to credit and/or debit the same such account. **PLEASE ATTACH A VOID CHECK TO THIS AUTHORIZATION FORM.**

Employee Full Name: _____

Employee SS#: _____

Campus: _____

Phone Number: _____

.....

Bank Information:

Bank Name: _____

Routing/Transit #: _____

Account#: _____

Type of account for net pay: (Circle One) Checking Savings

This banking information will remain active until employee has given written notification to Comanche ISD of its termination with this banking institution. Written notification must be submitted two weeks prior to pay date for the new banking institution to become effective.

I am an authorized signatory on the above listed checking/savings account.

Authorized Employee Signature: _____

Date: _____

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

Employee Name _____ Employee ID# _____
Employer Name Comanche ISD Employer ID# 75-6000765

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

Windfall Elimination Provision

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

Government Pension Offset Provision

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

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

For More Information

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

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

Signature of Employee _____ Date _____

Information about Social Security Form SSA-1945 Statement Concerning Your Employment in a Job Not Covered by Social Security

New legislation [Section 419(c) of Public Law 108-203, the Social Security Protection Act of 2004] requires State and local government employers to provide a statement to employees hired January 1, 2005 or later in a job not covered under Social Security. The statement explains how a pension from that job could affect future Social Security benefits to which they may become entitled.

Form SSA-1945, **Statement Concerning Your Employment in a Job Not Covered by Social Security**, is the document that employers should use to meet the requirements of the law. The SSA-1945 explains the potential effects of two provisions in the Social Security law for workers who also receive a pension based on their work in a job not covered by Social Security. The Windfall Elimination Provision can affect the amount of a worker's Social Security retirement or disability benefit. The Government Pension Offset Provision can affect a Social Security benefit received as a spouse, surviving spouse, or an ex-spouse.

Employers must:

- Give the statement to the employee prior to the start of employment;
- Get the employee's signature on the form; and
- Submit a copy of the signed form to the pension paying agency.

Social Security will not be setting any additional guidelines for the use of this form.

Copies of the SSA-1945 are available online at the Social Security website, www.socialsecurity.gov/online/ssa-1945.pdf. Paper copies can be requested by email at ofsm.oswm.rqct.orders@ssa.gov or by fax at 410-965-2037. The request must include the name, complete address and telephone number of the employer. Forms will not be sent to a post office box. Also, if appropriate, include the name of the person to whom the forms are to be delivered. The forms are available in packages of 25. Please refer to Inventory Control Number (ICN) 276950 when ordering.

Election to Annualize Compensation
Contract or Employment Agreement Employees

In accordance with 26 C.F.R. § 1.409A-2 (a)(14), I elect to be paid 10 or 11 months of compensation under my contract or employment agreement with Comanche ISD for the 2016-2017 school year over a 12-month period. The effect of this election is to defer a portion of the compensation I earn in the 2016 tax year to be paid in the 2017 tax year.

I understand that if I do not elect this method of compensation that the District will withhold additional amounts from compensation earned and paid in 2016 in order to pre-pay my contribution of the premium amounts necessary to cover health and hospitalization insurance benefits for the months of July and August 2017.

I further understand that should my employment be terminated for any reason (including my resignation from employment) during the 2016-2017 school year with an effective date on or before the last day of the instructional year, I will be paid all outstanding compensation no later than the next regular payroll date following the date of termination of employment. *See Policy DEA*

Employee Name (Printed)

Employee Signature

Date



Employment Eligibility Verification
Department of Homeland Security
 U.S. Citizenship and Immigration Services

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

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

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

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

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

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

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

<input type="checkbox"/> 1. A citizen of the United States	
<input type="checkbox"/> 2. A noncitizen national of the United States <i>(See instructions)</i>	
<input type="checkbox"/> 3. A lawful permanent resident (Alien Registration Number/USCIS Number): _____	
<input type="checkbox"/> 4. An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy): _____ Some aliens may write "N/A" in the expiration date field. <i>(See instructions)</i>	
<p><i>Aliens authorized to work must provide only one of the following document numbers to complete Form I-9: An Alien Registration Number/USCIS Number OR Form I-94 Admission Number OR Foreign Passport Number.</i></p> <p>1. Alien Registration Number/USCIS Number: _____ OR 2. Form I-94 Admission Number: _____ OR 3. Foreign Passport Number: _____ Country of Issuance: _____</p>	
<div style="border: 1px solid black; padding: 5px; width: fit-content; margin: 0 auto;"> QR Code - Section 1 Do Not Write In This Space </div>	

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

Preparer and/or Translator Certification (check one):

I did not use a preparer or translator. A preparer(s) and/or translator(s) assisted the employee in completing Section 1.
(Fields below must be completed and signed when preparers and/or translators assist an employee in completing Section 1.)

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

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



Employer Completes Next Page





Employment Eligibility Verification
Department of Homeland Security
 U.S. Citizenship and Immigration Services

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

Section 2. Employer or Authorized Representative Review and Verification

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

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

List A Identity and Employment Authorization	OR	List B Identity	AND	List C Employment Authorization
Document Title		Document Title		Document Title
Issuing Authority		Issuing Authority		Issuing Authority
Document Number		Document Number		Document Number
Expiration Date (if any)(mm/dd/yyyy)		Expiration Date (if any)(mm/dd/yyyy)		Expiration Date (if any)(mm/dd/yyyy)
Document Title		Additional Information		QR Code - Sections 2 & 3 Do Not Write In This Space
Issuing Authority				
Document Number				
Expiration Date (if any)(mm/dd/yyyy)				
Document Title				
Issuing Authority				
Document Number				
Expiration Date (if any)(mm/dd/yyyy)				

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

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

Signature of Employer or Authorized Representative <i>Lisa Warren</i>		Today's Date(mm/dd/yyyy)	Title of Employer or Authorized Representative <i>Payroll clerk</i>	
Last Name of Employer or Authorized Representative <i>Warren</i>	First Name of Employer or Authorized Representative <i>Lisa</i>	Employer's Business or Organization Name		
Employer's Business or Organization Address (Street Number and Name) <i>1414 N Austin</i>		City or Town <i>Comanche</i>	State <i>TX</i>	ZIP Code <i>76442</i>

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

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

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

Document Title	Document Number	Expiration Date (if any) (mm/dd/yyyy)
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I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented document(s), the document(s) I have examined appear to be genuine and to relate to the individual.

Signature of Employer or Authorized Representative	Today's Date (mm/dd/yyyy)	Name of Employer or Authorized Representative
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COMANCHE ISD
LETTER OF REASONABLE ASSURANCE - SUBSTITUTES

Dear _____:

This letter provides notice of reasonable assurance of continued employment with the district when each school term resumes after a scheduled school break. By virtue of this notice, please understand that you may not be eligible for unemployment insurance benefits drawn on school district wages during any scheduled school breaks including, but not limited to, the summer, winter, and spring breaks. This assurance is contingent upon continued school operations and will not apply in the event of any disruption that is beyond the control of the district (e.g., lack of school funding, natural disasters, court orders, public insurrections, war, etc.).

This is not an employment contract. Your continued employment is on an at-will basis. Employers may terminate at-will employees at any time for any reason or for no reason, except for legally impermissible reasons. At-will employees are free to resign at any time for any reason or for no reason.

Your services on behalf of the children of the district are appreciated, and we hope that you will be able to continue your association with the district.

Sincerely,



Superintendent

.....

Please complete the following information and return the original to **Lisa Warren** by _____, _____ . **Failure to sign and return this letter by this date will be treated as a voluntary resignation.**

Name (Print)

Last 4 Digits of SS#

Address

City, State

ZIP Code

E-mail

Telephone

Signature

Date

Comanche Independent School District

Non-Release of Employee Information

I, _____, wish that the following information not be made public through the public information act.

- Home Address
- Home Telephone Number
- Emergency Contact Information
- Social Security Number
- Information About Family Members

Employee Name (Please Print)

Employee Signature

Date

**I NEED EVERYONE TO FILL THIS OUT AND GET IT BACK
TO ME OR THE SECRETARIES AS SOON AS POSSIBLE.**

THANK YOU

EMPLOYEE NAME:

Phone Number:

Cell Number:

EMERGENCY CONTACT INFORMATION

Name:

Relationship:

Their Phone Number:

**Comanche Independent School District
Texas Public School Student/Staff Ethnicity and Race Data Questionnaire**

The United States Department of Education (USDE) requires all state and local education institutions to collect data on ethnicity and race for students and staff. This information is used for state and federal accountability reporting as well as for reporting to the Office of Civil Rights (OCR) and the Equal Employment Opportunity Commission (EEOC).

School district staff and parents or guardians of students enrolling in school are requested to provide this information. If you decline to provide this information, please be aware that the USDE requires school districts to use observer identification as a last resort for collecting the data for federal reporting.

Please answer both parts of the following questions on the student's or staff member's ethnicity and race. *United States Federal Register (71 FR 44866)*

Part 1. Ethnicity: Is the person Hispanic/Latino? (Choose only one)

- Hispanic/Latino** - A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.
- Not Hispanic/Latino**

Part 2. Race: What is the person's race? (Choose one or more)

- American Indian or Alaska Native** - A person having origins in any of the original peoples of North and South America (including Central America), and who maintains a tribal affiliation or community attachment.
- Asian** - A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.
- Black or African American** - A person having origins in any of the black racial groups of Africa.
- Native Hawaiian or Other Pacific Islander** - A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.
- White** - A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

Student/Staff Name (please print)

(Parent/Guardian)/(Staff) Signature

Student/Staff Identification Number

Date

Comanche Independent School District Drug Abuse Policy

1. ***Statement of Purpose and Scope***

Comanche ISD recognizes that alcohol and drug abuse in the work place has become a major concern. We believe that by reducing drug and alcohol abuse, we will improve the safety, health, and productivity of employees. The object of our drug abuse policy is to provide a safe and healthy work place for all employees prevent accidents and comply with Section 7.10 of the Texas Worker's Compensation Act.

The use, possession, sale, transfer, purchase or being under the influence of drugs by employees at any time on company premises or while on company business is prohibited. The illegal use of any drug is prohibited. Employees must not report for duty or be on company property while under the influence of, or have in their possession while on company property, any drug.

2. ***Definition of Drug***

For the purpose of this policy, the term "drug," wherever it appears in this policy statement, includes alcoholic beverages as well as inhalants and illegal drugs.

3. ***Consequences of Violating the Drug Abuse Policy***

Violation of this drug abuse policy will result in one of the following forms of corrective action: Immediate discharge, suspension, probation, oral warning or written warning. In arriving at a decision for proper action, the seriousness of the infraction, the past record of the employee, and the circumstances surrounding the matter will be taken into consideration.

4. ***Treatment Programs***

While we do not sponsor or endorse any specific drug treatment programs, such programs are available through public and private health care facilities in our area. Affected employees are encouraged to seek assistance for themselves and their dependents.

5. ***Education and Training Programs***

We do not offer, nor require participation in, drug and alcohol abuse education and training programs. However, various public and private facilities in our area offer such programs and affected employees are encouraged to seek assistance.

6. ***Drug Testing***

Drug testing is a condition of employment for bus drivers in our school district.

I have read and understand this drug abuse policy and agree to abide by its terms and conditions.

Employee Signature

Date

ACKNOWLEDGEMENT OF ELECTRONIC DISTRIBUTION OF POLICIES

I hereby acknowledge that I have been offered the option to receive a paper copy or to electronically access at www.comancheisd.net the Board policies regarding employment as required under Education Code 21.204(d) and the Board policies regarding student discipline as required under Education Code 37.018.

I have chosen to:

Receive a paper copy of the policies.

Accept responsibility for accessing the policies through an accessible District computer and printer.

I have been trained to access these policies from the District's Web page and understand that if I have any questions regarding these policies, I should direct those questions to my principal or immediate supervisor.

Employee Name (Printed) _____

Employee signature _____

Campus or department _____

Date _____

Comanche ISD provides health coverage to employees through TRS-ActiveCare. A district substitute is eligible to enroll in TRS-ActiveCare if the district reasonably expects the substitute to work at least 130 hours per month. Hours worked for other school districts are not considered in determining whether a substitute is eligible for benefits through Comanche ISD.

The district does not guarantee that you will receive 130 hours per month. The district’s need for substitutes varies from week to week. In some weeks, you may not receive any assignments. Similarly, the district understands that some weeks you may not be able to accept assignments due to illness or other personal reasons.

If you are a new substitute, you must enroll in or decline medical coverage within 31 days from date of hire. If you are a returning substitute, you must enroll in or decline medical coverage during the annual open enrollment or no later than August 31st of that year. If you decline coverage, you cannot enroll again until the next plan year unless you experience a special enrollment event.

If you elect to enroll, **you will be responsible for the full premium.** You must submit payment for one calendar month with your enrollment form. The premiums for subsequent months will be deducted from your pay for the preceding month. If your pay is not sufficient to cover the full premium, you must submit the difference to the district by the 1st day of the preceding month. If the 1st day falls on a weekend or a day the district is closed, the payment must be made the preceding business day. If you fail to timely pay the monthly premiums, the district will proceed with the coverage cancellation process. Your coverage may also be cancelled if you lose eligibility for TRS-ActiveCare.

You may be removed from the district’s substitute roster for poor performance or misconduct. In addition, you may be removed from the substitute roster if:

- you repeatedly turn down assignments, are repeatedly unavailable for calls, or frequently cancel assigned positions
- you do not timely return a letter of reasonable assurance

A substitute who is enrolled in TRS-Active Care and who is then removed from the substitute roster becomes ineligible for health coverage and will be provided notice regarding continuation coverage under COBRA (if eligible). Cancellation due to non-payment is considered a voluntary drop: Therefore you would not be eligible for COBRA.

Substitute Signature

Date

- Declining Health Insurance
- Enrolling in Health Insurance



ELIGIBILITY:	Are you an active employee and making monthly contributions to TRS? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, are you regularly scheduled to work 10 or more hours per week? <input type="checkbox"/> Yes <input type="checkbox"/> No	(If no to both, you are not eligible for TRS ActiveCare coverage)
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SECTION 1: ENROLLMENT/CHANGE TRANSACTION TYPE

<input type="checkbox"/> Annual Enrollment <input type="checkbox"/> New Employee <input type="checkbox"/> Add Dependent <input type="checkbox"/> Special Enrollment				For District Use Only
<input type="checkbox"/> For New Employee (check one): <input type="checkbox"/> Effective on Actively at Work <input type="checkbox"/> Effective 1 st day of month following				TRS District #
Special Enrollment Event Date: ___/___/___				Actively at Work Date:
<input type="checkbox"/> Marriage <input type="checkbox"/> Court Order <input type="checkbox"/> Birth/Adoption <input type="checkbox"/> Loss of Coverage <input type="checkbox"/> Other: _____				Effective/Change Date:
Change Only:	Decline Coverage:	Cancel Employee	Cancel Dependent	Employer Approval:
<input type="checkbox"/> Name <input type="checkbox"/> Address <input type="checkbox"/> Plan/Coverage	<input type="checkbox"/> Yes (Complete Section 6) <input type="checkbox"/> N/A Effective Date of Change/Cancel: ___/___/___	<input type="checkbox"/> Death <input type="checkbox"/> Loss of Eligibility <input type="checkbox"/> Retirement/Terminated <input type="checkbox"/> Non-Payment <input type="checkbox"/> Other: _____	<input type="checkbox"/> Divorce <input type="checkbox"/> Death <input type="checkbox"/> Loss of Eligibility <input type="checkbox"/> Dropped Coverage <input type="checkbox"/> Other: _____	Were you covered by another district? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, which: _____

SECTION 2: EMPLOYEE INFORMATION

Last Name:	First Name:	MI:	Social Security #:
Mailing Address:		City:	State: Zip:
Home Phone Number:	Cell Phone Number:		Email:
Date of Birth:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Language: <input type="checkbox"/> English <input type="checkbox"/> Spanish	Ethnicity:
Do you have a disability affecting your ability to communicate or read? <input type="checkbox"/> Yes (Please complete Section 8) <input type="checkbox"/> No			
Is the Employee Covered By Other Insurance? <input type="checkbox"/> Yes Carrier/Plan: _____ <input type="checkbox"/> No			
Is the Employee Covered by Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> Part A <input type="checkbox"/> Part B <input type="checkbox"/> Part C <input type="checkbox"/> Part D Effective: <input type="checkbox"/> No			
Reason for Medicare Coverage: <input type="checkbox"/> Entitlement Age <input type="checkbox"/> Disability <input type="checkbox"/> End Stage Renal Disease (ESRD)			

SECTION 3: COVERAGE SELECTION (Please select a Plan of Coverage – Plan or HMO - and Coverage Type)

Plan Selection: <input type="checkbox"/> ActiveCare 1-HD <input type="checkbox"/> ActiveCare Select <input type="checkbox"/> ActiveCare 2
HMO Selection: <input type="checkbox"/> FirstCare Health Plans <input type="checkbox"/> Scott & White Health Plan <input type="checkbox"/> Allegian Health Plans (formerly Valley Baptist Health Plans)
Coverage Type Selected: <input type="checkbox"/> Employee Only <input type="checkbox"/> Employee + Spouse <input type="checkbox"/> Employee + Child(ren) <input type="checkbox"/> Employee + Family

SECTION 4: DEPENDENT INFORMATION (Use additional form for additional dependents)

SPOUSE Last Name:		First Name:		MI:
Street Address:				<input type="checkbox"/> Same as Employee
City:		State:	Zip:	Phone Number:
Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth:		Social Security #:	
Other Insurance: <input type="checkbox"/> Yes. Carrier/Plan <input type="checkbox"/> No <input type="checkbox"/> Medicare: <input type="checkbox"/> Part A <input type="checkbox"/> Part B <input type="checkbox"/> Part C <input type="checkbox"/> Part D				
CHILD Last Name:		First Name:		MI:
<input type="checkbox"/> Natural/Adopted <input type="checkbox"/> Stepchild <input type="checkbox"/> Foster Child <input type="checkbox"/> Grandchild <input type="checkbox"/> Legal Guardian <input type="checkbox"/> Disabled <input type="checkbox"/> Other				
Street Address:				<input type="checkbox"/> Same as Employee
City:		State:	Zip Code:	Phone Number:
Date of Birth:	Social Security #:		Sex: <input type="checkbox"/> M <input type="checkbox"/> F	
Other Insurance: <input type="checkbox"/> Yes. Carrier/Plan <input type="checkbox"/> No <input type="checkbox"/> Medicare: <input type="checkbox"/> Part A <input type="checkbox"/> Part B <input type="checkbox"/> Part C <input type="checkbox"/> Part D				
CHILD Last Name:		First Name:		MI:
<input type="checkbox"/> Natural/Adopted <input type="checkbox"/> Stepchild <input type="checkbox"/> Foster Child <input type="checkbox"/> Grandchild <input type="checkbox"/> Legal Guardian <input type="checkbox"/> Disabled <input type="checkbox"/> Other				
Street Address:				<input type="checkbox"/> Same as Employee
City:		State:	Zip Code:	Phone Number:
Date of Birth:	Social Security #:		Sex: <input type="checkbox"/> M <input type="checkbox"/> F	
Other Insurance: <input type="checkbox"/> Yes. Carrier/Plan <input type="checkbox"/> No <input type="checkbox"/> Medicare: <input type="checkbox"/> Part A <input type="checkbox"/> Part B <input type="checkbox"/> Part C <input type="checkbox"/> Part D				

Natural/Adopted Stepchild Foster Child Grandchild Legal Guardian Disabled Other

Street Address: _____ Same as Employee

City: _____ State: _____ Zip Code: _____ Phone Number: _____

Date of Birth: _____ Social Security #: _____ Sex: M F

Other Insurance: Yes. Carrier/Plan No Medicare: Part A Part B Part C Part D

CHILD Last Name: _____ First Name: _____ MI: _____

Natural/Adopted Stepchild Foster Child Grandchild Legal Guardian Disabled Other

Street Address: _____ Same as Employee

City: _____ State: _____ Zip Code: _____ Phone Number: _____

Date of Birth: _____ Social Security #: _____ Sex: M F

Other Insurance: Yes. Carrier/Plan No Medicare: Part A Part B Part C Part D

SECTION 5: DISABLED DEPENDENTS OVER AGE 26 Request for Continuation of Coverage for Handicapped Child form and Attending Physician's Statement

Please note that a Request for Continuation of Coverage for Handicapped Child form and Attending Physician's Statement are required for coverage of a disabled child over age 26. See your Benefits Administrator for the forms, which must be completed in full and submitted to your Benefits Administrator.

SECTION 6: DECLINATION OF COVERAGE

This is to certify that the available coverage has been explained to me. I have been given the opportunity to apply for the coverage available to me and my dependents and have voluntarily elected to decline the coverage as elected below.

Name: _____	SSN: _____	<input type="checkbox"/> Employee	Reason: <input type="checkbox"/> Other Coverage	<input type="checkbox"/> Other:
Name: _____		<input type="checkbox"/> Spouse	Reason: <input type="checkbox"/> Other Coverage	<input type="checkbox"/> Other:
Name: _____		<input type="checkbox"/> Child	Reason: <input type="checkbox"/> Other Coverage	<input type="checkbox"/> Other:
Name: _____		<input type="checkbox"/> Child	Reason: <input type="checkbox"/> Other Coverage	<input type="checkbox"/> Other:
Name: _____		<input type="checkbox"/> Child	Reason: <input type="checkbox"/> Other Coverage	<input type="checkbox"/> Other:
Name: _____		<input type="checkbox"/> Child	Reason: <input type="checkbox"/> Other Coverage	<input type="checkbox"/> Other:

SECTION 7: COVERAGE CONDITIONS

- I am employed by the Employer named in this Enrollment Application and Change Form. I am eligible to participate in the coverage(s) offered by the TRS-ActiveCare program which is administered by Aetna, with HMO benefits provided by SHA, L.L.C. dba FirstCare Health Plan, Scott and White Health Plan, and Allegian Insurance Company dba Allegian Health Plans. On behalf of myself and any dependents listed on their Enrollment Application and Change Form, I apply for those coverage(s) for which I am eligible.
 - If I am enrolling a grandchild in Section 4, I certify that my household is the grandchild's primary residence and the grandchild is my dependent for federal income tax purposes for the reporting year in which coverage of the grandchild is in effect.
 - If I am enrolling a child as an "other Child" in Section 4, I certify that my household is the child's primary residence, that I provide at least 50% of the child support, that neither of the children's natural parents reside in my household, and that I have the legal right to make decisions regarding the child's medical care.
- Only those coverage(s) and amount for which I am eligible will be available to me. I understand that if this Enrollment Application and Change Form is accepted, the coverage(s) will become effective in accordance with the provisions or the TRS-ActiveCare program.
- I understand that by enrolling for coverage with Employer named in the Enrollment Application and Change Form that any TRS-ActiveCare coverage I previously elected under another TRS-ActiveCare participating district/entity will be terminated under TRS Rules.
- I authorize necessary payroll deduction by my Employer, if any, to cover the cost of my coverage(s). I agree that my Employer acts as my agent. All notices given to my Employer are binding upon me. I also agree that my participation in the coverage(s) is subject to any future amendments.
- I understand that by declining TRS-ActiveCare coverage now or by terminating TRS-ActiveCare coverage during the plan year, I am not eligible to re-enroll in TRS-ActiveCare until the next plan year, unless I experience a special enrollment event.
- I state that the information given on the Enrollment Application and Change Form is true and correct. I understand and agree that any incorrect statements material to the risk and knowingly made by me will invalidate my coverage(s).

Applicant Signature: _____ Date: _____

SECTION 8: SPECIAL NOTES REGARDING MY ENROLLMENT (Please indicate any special information regarding my enrollment for Aetna, Caremark or my selected HMO)