CADDO PARISH SCHOOL BOARD
PERSONNEL DEPARTMENT
1961 MIDWAY STREET
SHREVEPORT, LOUISIANA 71108
(318) 603-6300

TO: New Employee
Personnel Department

SUBJECT: **Information Release Preference**

Each year professional organizations and other groups request information about employees in our school system.

Please complete the information below by checking the appropriate "Yes" or "No" choice. Your signature verifies that you have had an opportunity to respond to this request.

If you check "Yes" under the demographics item, you are authorizing the Personnel Department to release your name, home address and job classification to organizations who request such information.

If you check "Yes" under the home telephone item, you are authorizing the Personnel Department to release your home telephone number along with the demographic information to organizations who request such information.

I appreciate your cooperation.

INFORMATION RELEASE PREFERENCE WORKSHEET

DEMOGRAPHIC	HOME TELEPHONE NUMBER
Yes_____ No_____	Yes_____ No_____

NAME: _____

SIGNATURE: _____

SOCIAL SECURITY NUMBER: _____

DATE: _____

Employment Eligibility Verification

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

USCIS
Form I-9
OMB No.1615-0047
Expires 07/31/2026

START HERE: Employers must ensure the form instructions are available to employees when completing this form. Employers are liable for failing to comply with the requirements for completing this form. See below and the Instructions.

ANTI-DISCRIMINATION NOTICE: All employees can choose which acceptable documentation to present for Form I-9. Employers cannot ask employees for documentation to verify information in Section 1, or specify which acceptable documentation employees must present for Section 2 or Supplement B, Reverification and Rehire. Treating employees differently based on their citizenship, immigration status, or national origin may be illegal.

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 (if any)	Other Last Names Used (if any)

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

Date of Birth (mm/dd/yyyy)	U.S. Social Security Number	Employee's Email Address	Employee's Telephone Number

I am aware that federal law provides for imprisonment and/or fines for false statements, or the use of false documents, in connection with the completion of this form. I attest, under penalty of perjury, that this information, including my selection of the box attesting to my citizenship or immigration status, is true and correct.

Check one of the following boxes to attest to your citizenship or immigration status (See page 2 and 3 of the instructions.):

- ☐ 1. A citizen of the United States
- ☐ 2. A noncitizen national of the United States (See Instructions.)
- ☐ 3. A lawful permanent resident (Enter USCIS or A-Number.)
- ☐ 4. A noncitizen (other than Item Numbers 2. and 3. above) authorized to work until (exp. date, if any)

If you check Item Number 4., enter one of these:

USCIS A-Number	OR	Form I-94 Admission Number	OR	Foreign Passport Number and Country of Issuance

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

If a preparer and/or translator assisted you in completing Section 1, that person MUST complete the Preparer and/or Translator Certification on Page 3.

Section 2. Employer Review and Verification: Employers or their authorized representative must complete and sign Section 2 within three business days after the employee's first day of employment, and must physically examine, or examine consistent with an alternative procedure authorized by the Secretary of DHS, documentation from List A OR a combination of documentation from List B and List C. Enter any additional documentation in the Additional Information box; see Instructions.

	List A	OR	List B	AND	List C
Document Title 1					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 2 (if any)			Additional Information		
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 3 (if any)					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)			☐ Check here if you used an alternative procedure authorized by DHS to examine documents.		

Certification: I attest, under penalty of perjury, that (1) I have examined the documentation presented by the above-named employee, (2) the above-listed documentation appears 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.	First Day of Employment (mm/dd/yyyy):

Last Name, First Name and Title of Employer or Authorized Representative	Signature of Employer or Authorized Representative	Today's Date (mm/dd/yyyy)

Employer's Business or Organization Name	Employer's Business or Organization Address, City or Town, State, ZIP Code

For reverification or rehire, complete Supplement B, Reverification and Rehire on Page 4.

LISTS OF ACCEPTABLE DOCUMENTS

All documents containing an expiration date must be unexpired.
* Documents extended by the issuing authority are considered unexpired.
Employees may present one selection from List A or a combination of one selection from List B and one selection from List C.
Examples of many of these documents appear in the Handbook for Employers (M-274).

LIST A Documents that Establish Both Identity and Employment Authorization	OR	LIST B Documents that Establish Identity	AND	LIST C Documents that Establish Employment Authorization
1. U.S. Passport or U.S. Passport Card		1. Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		1. A Social Security Account Number card, unless the card includes one of the following restrictions: (1) NOT VALID FOR EMPLOYMENT (2) VALID FOR WORK ONLY WITH INS AUTHORIZATION (3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION
2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)		2. ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		2. Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240)
3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa		3. School ID card with a photograph		3. Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal
4. Employment Authorization Document that contains a photograph (Form I-766)		4. Voter's registration card		4. Native American tribal document
5. For an individual temporarily authorized to work for a specific employer because of his or her status or parole: a. Foreign passport; and b. Form I-94 or Form I-94A that has the following: (1) The same name as the passport; and (2) An endorsement of the individual's status or parole as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form.		5. U.S. Military card or draft record		5. U.S. Citizen ID Card (Form I-197)
		6. Military dependent's ID card		6. Identification Card for Use of Resident Citizen in the United States (Form I-179)
		7. U.S. Coast Guard Merchant Mariner Card		7. Employment authorization document issued by the Department of Homeland Security For examples, see Section 7 and Section 13 of the M-274 on uscis.gov/i-9-central. The Form I-766, Employment Authorization Document, is a List A, Item Number 4. document, not a List C document.
		8. Native American tribal document		
		9. Driver's license issued by a Canadian government authority		
		For persons under age 18 who are unable to present a document listed above:		
		10. School record or report card		
		11. Clinic, doctor, or hospital record		
		12. Day-care or nursery school record		
6. Passport from the Federated States of Micronesia (FSM) or the Republic of the Marshall Islands (RMI) with Form I-94 or Form I-94A indicating nonimmigrant admission under the Compact of Free Association Between the United States and the FSM or RMI				

Acceptable Receipts

May be presented in lieu of a document listed above for a temporary period.
For receipt validity dates, see the M-274.

◦ Receipt for a replacement of a lost, stolen, or damaged List A document. ◦ Form I-94 issued to a lawful permanent resident that contains an I-551 stamp and a photograph of the individual. ◦ Form I-94 with "RE" notation or refugee stamp issued to a refugee.	OR	Receipt for a replacement of a lost, stolen, or damaged List B document.	Receipt for a replacement of a lost, stolen, or damaged List C document.

*Refer to the Employment Authorization Extensions page on I-9 Central for more information.

Form **W-4**

Department of the Treasury
Internal Revenue Service

Employee's Withholding Certificate

Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay.
Give Form W-4 to your employer.
Your withholding is subject to review by the IRS.

OMB No. 1545-0074

2025

Step 1: Enter Personal Information

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

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

TIP: Consider using the estimator at *www.irs.gov/W4App* to determine the most accurate withholding for the rest of the year if: you are completing this form after the beginning of the year; expect to work only part of the year; or have changes during the year in your marital status, number of jobs for you (and/or your spouse if married filing jointly), dependents, other income (not from jobs), deductions, or credits. Have your most recent pay stub(s) from this year available when using the estimator. At the beginning of next year, use the estimator again to recheck your withholding.

Complete Steps 2–4 ONLY if they apply to you; otherwise, skip to Step 5. See page 2 for more information on each step, who can claim exemption from withholding, and when to use the estimator at *www.irs.gov/W4App*.

Step 2: Multiple Jobs or Spouse Works

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

Do **only one** of the following.

(a) Use the estimator at *www.irs.gov/W4App* for the most accurate withholding for this step (and Steps 3–4). If you or your spouse have self-employment income, use this option; **or**

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

(c) If there are only two jobs total, you may check this box. Do the same on Form W-4 for the other job. This option is generally more accurate than (b) if pay at the lower paying job is more than half of the pay at the higher paying job. Otherwise, (b) is more accurate . . . . . ☐

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

Step 3: Claim Dependent and Other Credits

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

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

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

Add the amounts above for qualifying children and other dependents. You may add to this the amount of any other credits. Enter the total here . . . . . **3** $

Step 4 (optional): Other Adjustments

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

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

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

Step 5: Sign Here

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

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

Employers Only

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

R-1300 (4/01)

State of Louisiana
Department of Revenue

Employee Withholding Exemption Certificate (L-4)

Purpose: Complete form L-4 so that your employer can withhold the correct amount of state income tax from your salary.

Basic Instructions: Employees who are subject to state withholding should complete the personal allowances worksheet below. Do not claim more than your correct withholding personal exemptions and the correct number of withholding dependency credits. Do not claim additional withholding exemptions if you qualify as head-of-household. In such cases, only the withholding personal exemption applicable to single individuals is allowable. You must file a new certificate within 10 days if the number of your exemptions decreases, except where the change occurs as the result of death of a spouse or a dependent. You may file a new certificate at any time the number of your exemptions increases. Penalties are imposed for willfully supplying false information or willful failure to supply information that would reduce the withholding exemption. This form must be filed with your employer. Otherwise, he must withhold Louisiana income tax from your wages without exemption.

Note to Employer: Keep this certificate with your records. If the employee is believed to have claimed too many exemptions or dependency credits, the Secretary of Revenue should be so advised by forwarding a copy of the employee's signed L-4 form to the Department.

Personal Allowances Worksheet

A. In Block A, enter "0" if you claim neither yourself nor your spouse, or

In Block A, enter "1" if you claim yourself, provided you do not claim this exemption in connection with other employment or your spouse has not claimed your exemption, or

In Block A, enter "2" if you claim yourself and your spouse. You may choose to enter "0" if you are married, and have either a working spouse, or more than one job. (This may help you avoid having too little tax withheld.)

A. ____

B. In Block B, enter the number of dependents (other than your spouse or yourself) whom you will claim on your tax return. If no credits are claimed, enter "0".

B. ____

—— Cut here and give the bottom portion of certificate to your employer. Keep the top portion for your records. ——

Form L-4
Louisiana Department of Revenue

Employee's Withholding Allowance Certificate

1. Type or print first name and middle initial ____ Last name ____

2. Social Security Number ____

3. ☐ No exemptions or dependents claimed ☐ Single ☐ Married

4. Home address (number and street or rural route) ____

5. City, State, ZIP ____

6. Total number of exemptions you are claiming (from Block A above) — 6. ____

7. Total number of dependents you are claiming (from Block B above) — 7. ____

8. Additional amount, if any, you want withheld each pay period — 8. ____

I declare under the penalties imposed for filing false reports that the number of exemptions and dependency credits claimed on this certificate do not exceed the number to which I am entitled.

Employee's signature ____ Date ____

The following is to be completed by employer.

9. Employer's name and address ____

10. Employer's state withholding account number ____

DEFFERED COMPENSATION PLAN PARTICIPATION AGREEMENT

FICA ALTERNATIVE PST PLAN

☐ NEW ENROLLMENT ☐ ADDRESS CHANGE ☐ BENEFICIARY CHANGE NAME CHANGE

PARTICIPANT INFORMATION

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

ADDRESS: _____
(Street / P. 0. Box) (Apt. #) (City) (State) (Zip)

SOCIAL SECURITY NUMBER: _____ BIRTH DATE: _____

HOME PHONE (____)_____ WORK PHONE (____)_____ FEMALE_____MALE_____

Beginning (Hire Date) _____. I will participate in the Caddo Parish Schools Deferred Compensation Plan, I.R.C. Section 457, and hereby forego my rights to receive compensation to the 7.5 % of my eligible gross annual compensation in return for the benefits provided thereunder. I with this contribution to be invested in an annuity contract with American United Life. I understand that my total amount of deferred compensation shall not exceed the lesser of the Section 457 dollar limit or 100% of the participant's includable compensation or such other sum as is permissible pursuant to the provisions of Section 457 of the Code in any calendar year. I understand that my participation in this Plan is a condition of employment required by I. R. C. Section 3121 (b) (7) OBRA 1990. I further understand that payment(s) will be based on the value of the individual account (s). I acknowledge that a copy of the Deferred Compensation Plan Document is available to me for my review and understanding. The terms, conditions, and provisions of the Plan Document are hereby incorporated into this agreement.

* NEW EMPLOYEES MUST COMPLETE THE FOLLOWING BENEFICIARY DESIGNATIONS.

PRIMARY: NAME_____ DATE OF BIRTH_____

RELATIONSHIP_____ SOCIAL SECURITY # _____

ADDRESS _____
(Street / P. 0. Box) (Apt. #) (City) (State) (Zip)

CONTINGENT: NAME_____ DATE OF BIRTH_____

RELATIONSHIP_____ SOCIAL SECURITY #_____

ADDRESS _____
(Street/P.O. Box) (Apt.#) (City) (State) (Zip)

A $1.00 monthly fee will be applied to inactive participant account balances. Inactive participants are those participants who have not made a contribution to the plan for one year, are no longer employed with the District, and who could, at any time, request a distribution of their account balance.

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

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 2005, the maximum monthly reduction in your Social Security benefit as a result of this provision is $313.50. This amount is updated annually. This provision reduces, but does not totally eliminate, your Social Security benefit. For additional information, please refer to the Social Security Publication, "Windfall Elimination Provision".

Government Pension Offset Provision

Under the Government Pension Offset Provision, and 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 the 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.

Form
SSA-1945
(12-2004)

SIGNATURE OF EMPLOYEE DATE EMPLOYER SIGNATURE DATE

FORM MUST BE SIGNED, DATED AND APPROVED BY THE EMPLOYER (PLAN SPONSOR)

CADDO PARISH SCHOOL BOARD

EMPLOYEES
EQUAL EMPLOYMENT OPPORTUNITY DATA

CADDO PARISH SCHOOL BOARD requests the following information for hiring records and EEO reporting. You must complete this information to become an employee.

SOCIAL SECURITY NUMBER _____

NAME _____

RACE _____ SEX _____ DATE OF BIRTH _____

PHONE: HOME (___)_____ WORK (___)_____ CELL (___)_____

IN CASE OF EMERGENCY CONTACT

LAST _____ FIRST _____ MI_____

RELATIONSHIP _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

PHONE: HOME (___)_____ WORK (___)_____ CELL (___)_____

SEXUAL MISCONDUCT DISCLOSURE STATEMENT

As required by Louisiana Statue 17:81.9, (Act 723), the applicant authorizes all previous city, parish, or other local public school system to disclose any and all information in the applicant's personnel file related to instances of sexual misconduct with students committed by the applicant. The applicant releases previous and current employers from liability for providing the requested information to the Caddo Parish School System.

- I have read and understand the statement above
- I also understand that I cannot be considered for employment in the Caddo Parish School System unless this form is signed.
- I agree that a copy of this form will be sent to each of my previous employers.
- Each completed form received will be placed in my personnel file.

Please check the appropriate entry:

☐ I have formerly worked in (a) school district(s) in the State of Louisiana.

☐ I have never worked in (a) school district(s) in the State of Louisiana.

PRINT FULL NAME _____ DATE _____

SIGNATURE OF EMPLOYEE _____ SOCIAL SECURITY NUMBER _____

****** THIS SECTIONTO BE COMPLETED BY PREVIOUS EMPLOYER*****

Name of School System _____

☐ There is no information in this employee's file indicating sexual misconduct.

☐ I have attached documentation regarding sexual misconduct.

Previous employer(s) should complete this form and return it within twenty (20) business days to the following address:

Caddo Parish School Board
Classified Human Resources Department
P.O. Box 3200
Shreveport, Louisiana 7113-2000

Shannon B. Henderson, CPSB Director/Human Resources _____ Date _____

Signature of Director, Human Resources: _____

STATEMENT OF NOTICE THAT THE CADDO PARISH SCHOOL BOARD HAS ADOPTED A DRUG AND ALCOHOL TESTING POLICY AND SHALL BECOME EFFECTIVE JANUARY 1, 1993

A COPY OF THIS NOTICE IS TO BE PROVIDED TO ALL EMPLOYEES OF THE CADDO PARISH SCHOOL SYSTEM.

Employees of the Caddo Parish School Board are explicitly prohibited from unlawfully manufacturing, making, distributing, dispensing, selling, possessing or illegal controlled substances or alcohol in the workplace or on school board property. The workplace is any Caddo Parish School Board property or any other site where employees in connection with a federal grant perform work.

The Caddo Parish School Board may request an employee to submit to a drug or alcohol test under the following headings:

1. Reasonable Suspicion Testing (any employee)
2. Post-Accident Testing (any employee)
3. Random Drug Testing (any employee identified as working within a safety or security-sensitive position)
4. Rehabilitation Testing (any employee in treatment or follow-on support conditions)
5. Periodic Physical Examination Testing (those employees required to have annual examinations)
6. Voluntary testing (any employee)

Drug/alcohol-testing is a condition of employment and accordingly it shall be the policy of the Caddo Parish School Board to comply vigorously with the requirements of the Drug-Free Workplace Act of 1988.

All employees are encouraged to comply with the Caddo Parish School Board requirements for a drug-free workplace and if any employee is in need of help; the Employee Assistance Program is available for any employee or family member who may need help in this area.

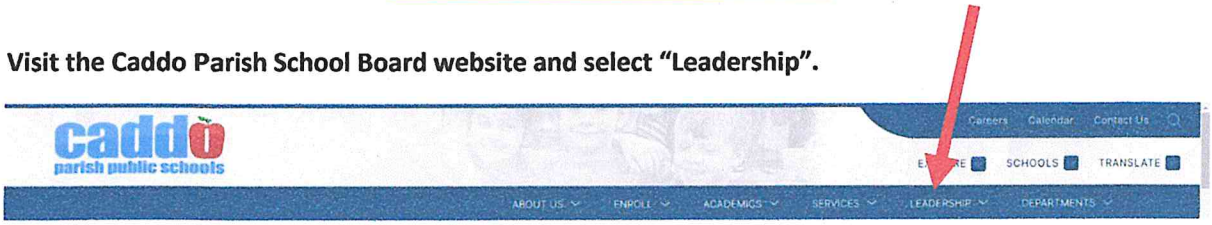
A copy of the Drug and Alcohol Testing policy can be obtained from your immediate supervisor.

Signature _____ Date _____

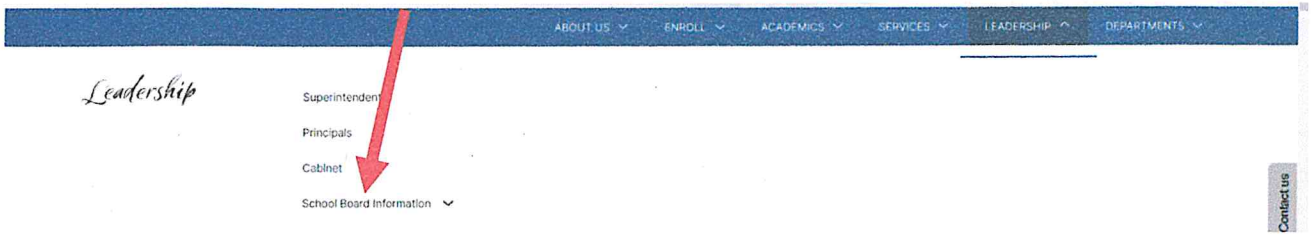
CPSB Policy Manual

www.caddoschools.org

Step 1: **Visit the Caddo Parish School Board website and select "Leadership".**



Step 2: **Select "School Board Information"**



Step 3: **Select "Board Policies PDF"**

My signature below indicates that I have been provided the above information regarding how to obtain the Caddo Parish School Board policy manual. I further understand that I am required to abide by all established policies outlined in both the CPSB and Louisiana state policy manuals. I acknowledge that it is my responsibility to periodically review the manual for any updates that may have occurred.

Signature _____ Date _____

Employee Acknowledgement of Policies

I understand that it is my responsibility to read, understand and comply with the Caddo Parish School Board's policies, any revisions made to it, and all other CPSB policies, practices and rules. The entire Policy Manual is available for review at schools and other building sites, on CPSB's website, and/or which is available upon request to the appropriate department of classified or certified personnel. Certain policies, including CPSB's anti-harassment policy (Policy GBCB), are also conspicuously posted in each building or site in central locations.

_____ Date: _____

Signature

_____

Printed Name

CADDO SCHOOLS RECOUPMENT OF OVERPAYMENTS

The Caddo Parish School System is required to make a reasonable effort to recoup overpayments to both active and separated employees. Payroll overpayments occur when compensation that is not owed to an employee is paid in error. This includes, but not limited to overpayment of wages, annual leave paid in error or erroneous refunds of deductions. Article 7, Section 14 of Louisiana State Constitution prohibits the donation of public funds, and Revised Statue 42:460 mandates the Division of Administration to make every employee aware of the rules and regulations for recoupment of overpayments made to state employees. Failure to do so is a violation of state law.

Caddo School System will recoup the overpayment in one of the following ways:

1. Direct deposit reversal
2. One-time deduction
3. Repayment plan that:
   Must be agreed to by employee and Director of Personnel
   Should not exceed current fiscal year. Anything beyond the current fiscal year requires approval from the Chief of Human Resource Officer.
4. Personal payment by cash, check, or money order
5. If the employee terminates his/her employment with the School System and owes overpayment, the employee will repay any unpaid balance of the overpayment in full from the employee's final paycheck upon separation.

No recoupment payment can bring the employees biweekly gross hourly wage amount below federal minimum wage. If the employee agrees to have a larger amount withheld, Caddo Schools will obtain written approval from the employee.

Caddo Schools will notify employees in writing before any recoupment is made including the date of overpayment, the amount, the plan of action and the employee options for the reimbursement as appropriate. The notification is not a request to the employee for permission to recoup. Should the employee not make arrangements with the Director of Personnel for a repayment plan, the overpayment will be deducted as a one-time deduction on the next available paycheck.

If Caddo Schools determines that an overpayment was made to an employee who is now separated from Caddo Schools, and we are unable to recoup overpayment made from them, we will contact our legal department to determine if recourse is warranted. The decision to pursue collection will be based on total dollar amount, time period of employee will be repaid.

All employees will be notified of this procedure. Agreement with this procedure is a condition of employment and an acknowledgment must be signed by all new hires. If an employee does not agree with the replacement, they can file a dispute with the appropriate Human Resource Director. If it is found that recoupment was done in error, the employee will be repaid.

My signature below acknowledges that I have read and understand the "Recoupment of Overpayments" and I will adhere to the Recoupment Policy as presented above.

Name (printed)	Employee ID/Social Security Number
Signature	Date

CADDO PARISH SCHOOL BOARD
1961 MIDWAY
Shreveport, LA 71108
318-603-6300

Statement of Notice that the Caddo Parish School Board employees listed below has been informed of the following policies:

- **Sexual Harassment/Bullying**
- **24 Hour Arrest Policy**
- **Salary Overpayment**

Employment of the Caddo Parish School Board are explicitly prohibited from harassing or bullying in the workplace or on school board property. The workplace is any Caddo Parish School Board property or any other site where employees in connection with CPSB.

All employees are encouraged to comply with the Caddo Parish School Board policies for a harassing and bullying free workplace. If any employee is in need of help; the Employee Assistance Program is available for employees or family members who may need help in this area. C.P.S.B. POLICY (GAEAA).

When an employee is arrested for committing a criminal offense other than a minor traffic violation, that employee must notify his or her supervisor and the appropriate Director of Personnel of the arrest, within 24 hours of the arrest. **Bus operators are required to report all traffic violations within 24 hours of the offense to the transportation supervisor. C.P.S.B. Policy (GBRA)**

Any incarcerated employee may authorize another person to act on that employee's behalf in notifying or providing documents to that employee's immediate supervisor and the Department of Human Resources.

A copy of the Sexual Harassment, Bullying, and 24 Hour Arrest reporting policy can be obtained from your immediate supervisor or from CPSB website.

SIGNATURE _____ SS/ID#:_____

DEPARTMENT: _____ DATE:_____

CADDO PARISH SCHOOL BOARD

1961 MIDWAY STREET • SHREVEPORT, LOUISIANA 71108
AREA CODE 318 • Telephone 603-6300 • Fax 631-5241

Keith Burton
Superintendent

PRINT YOUR NAME
1961 MIDWAY AVENUE
Shreveport, LA 71108

RE: Status of Employment

By signing below, I acknowledge that my employment with Caddo Parish Public School is temporary until a satisfactory criminal history and background check allows for any employment in accordance with state law.

Applicant's Signature

Date

CADDO PARISH SCHOOL BOARD
1961 MIDWAY (P.O. BOX 3200)
Shreveport, LA 71108
318-603-6300

MEMORANDUM

TO: ALL Substitute Employees
Substitute Employees, ISS Facilitators, Teacher's Aides, Multi Purposes, Clericals, Food Service, Custodians, Bus Drivers and Bus Attendants.

FROM: Shannon B. Henderson, Director
Classified Personnel/Human Resources

SUBJECT: Summer Checks/Unemployment Benefits

As an at-will employee, I hereby acknowledge that I will not receive any pay checks during the summer months when school is not in regular session and I do not qualify for unemployment benefits.

_____ _____

Signature Date

CADDO PARISH SCHOOL BOARD

DIRECT DEPOSIT EMPLOYEE AUTHORIZATION FORM

PLEASE READ AND RETURN TO THE PAYROLL DEPARTMENT
AUTHORIZATION AGREEMENT FOR DIRECT DEPOSIT (ACH CREDIT)

It is understood that this banking procedure is a courtesy extended by the Caddo Parish School Board and does not guarantee the bank's posting of the deposit any given date. Notice: This courtesy is limited to ONE ACCOUNT ONLY.

NAME: _____ SS NUMBER _____ DATE_____

PHONE NO: _____

NAME OF BANK OR CREDIT UNION _____

NAME ON ACCOUNT _____

TYPE OF ACCOUNT: CHECKING _____ SAVINGS _____

ROUTING NUMBER _____

ACCOUNT NUMBER _____

I acknowledge that it is my sole responsibility to maintain current and correct banking account information on the file with the Caddo Parish School Payroll Department.

PLEASE NOTE: IF YOU CLOSE THIS ACCOUNT AT YOUR FINANCIAL INSTITUTION, PLEASE CONTACT THE PAYROLL DEPARTMENT IMMEDIATELY AT 603-5572

_____

EMPLOYEE SIGNATURE

ATTACH A VOIDED CHECK OR COPY OF CHECK HERE
PLEASE USE TAPE DO NOT STAPLE

IN ORDER TO PARTICIPATE IN THE DIRECT DEPOSIT PROGRAM, THE BANK TRANSIT NUMBER AND YOUR ACCOUNT NUMBER IS REQUIRED TO INSURE PROPER ENTRIES. THIS INFORMATION WILL BE USED ONLY BY THE DIRECT DEPOSIT SUPERVISOR AND YOUR BANKING INSTITUTION.YOUR ACCOUNT NUMBER WILL BE KEPT SECURE AND CONFIDENTIAL. IF YOU ARE DEPOSITING TO A SAVINGS ACCOUNT AND HAVE NO CHECK TO ATTACH, PLEASE BE SURE YOU HAVE LISTED YOUR SAVINGS ACCOUNT NUMBER CORRECTLY OR SEE YOUR BANK.

LOUISIANA WORKERS' COMPENSATION SECOND INJURY BOARD
POST-HIRE/CONDITIONAL JOB OFFER KNOWLEDGE QUESTIONNAIRE

EMPLOYEE: The intent of this questionnaire is to provide your employer with knowledge about any pre-existing medical condition or disability which may entitle your employer to reimbursement from the Louisiana Workers' Compensation Second Injury Board in the event you suffer an on-the-job injury.[1] This reimbursement in no way affects the benefits owed to you by your employer or its insurance company under the Louisiana Workers' Compensation Act. La. R.S. 23:1021-1361. However, your failure to answer truthfully and/or correctly to any of the question on this questionnaire may result in a forfeiture of your workers' compensation benefits.

In order for your employer to be considered for reimbursement from the Second Injury Board, it has to show that it knowingly hired or retained you with a pre-existing medical condition or disability. To establish its knowledge, your employer is requesting that this questionnaire be completed.

INSTRUCTIONS: Please answer ALL questions completely. If a response requires an explanation, please provide a brief description on the Explanation Page. If you have any questions or need help in answering the questions on this form, please ask for assistance from the Employer Representative signing this form.

NOTE: Since this questionnaire contains medical information, you can request that the form be kept CONFIDENTIAL and not made part of your personnel file. Please let your employer know that you want the completed questionnaire placed in a sealed folder for confidentiality purposes.

EMPLOYEE WARNING

FAILURE TO ANSWER TRUTHFULLY AND/OR CORRECTLY TO ANY OF THE QUESTIONS ON THIS FORM MAY RESULT IN A FORFEITURE OF YOUR WORKERS' COMPENSATION BENEFITS UNDER La. R.S. 23:1208.1.

Employee Signature: _____ Date: _____

Employer Representative Signature: _____ Date: _____

Employer Name: _____

Employee Name: _____

Date of Birth (mm/dd/yyyy): _____ Male: ☐ Female: ☐

Soc. Sec. # (last 4 digits only): _____

Home Address: _____

Telephone Number: (____) _____

[1] Under La. R.S. 23:1371(A), the purpose of the Second Injury Board is to encourage the employment, re-employment, or retention of employees who have a permanent partial disability.

Disease and Other Medical Conditions you currently have or have ever had.

For all conditions that you check yes, write a brief explanation on the Explanation Page.

[Please check the appropriate box next to each. Every illness/injury requires a Yes (Y) or No (N) answer.]

Y N	Y N	Y N	Y N
☐ ☐ Diabetes	☐ ☐ Cerebral Palsy	☐ ☐ Arthritis	☐ ☐ Heart Disease/Heart Attack
☐ ☐ Silicosis	☐ ☐ Tuberculosis	☐ ☐ Parkinson's	☐ ☐ Congestive Heart Failure
☐ ☐ Varicose Veins	☐ ☐ Multiple Sclerosis	☐ ☐ Brain Damage	☐ ☐ Vision Loss, one or both eyes
☐ ☐ Asbestosis	☐ ☐ Post Traumatic Stress	☐ ☐ Asthma	☐ ☐ Disability from Polio
☐ ☐ Hyperinsulinism	☐ ☐ Osteomyelitis	☐ ☐ Dementia	☐ ☐ Psychoneurotic Disability
☐ ☐ Alzheimer's	☐ ☐ Nervous Disorder	☐ ☐ Thrombophlebitis	☐ ☐ Ruptured or Herniated Disc
☐ ☐ Emphysema	☐ ☐ Muscular Dystrophy	☐ ☐ Arteriosclerosis	☐ ☐ Ankylosis or Joint Stiffening
☐ ☐ Hearing Loss	☐ ☐ Migraine Headaches	☐ ☐ Hodgkin's	☐ ☐ High/Low Blood Pressure
☐ ☐ COPD	☐ ☐ Mental Retardation	☐ ☐ Cancer	☐ ☐ Carpal Tunnel Syndrome
☐ ☐ Hypertension	☐ ☐ Kidney Disorder	☐ ☐ Double Vision	☐ ☐ Compressed Air Sequelae
☐ ☐ Head Injury	☐ ☐ Loss of Use of Limb	☐ ☐ Mental Disorders	☐ ☐ Disease of the Lung
☐ ☐ Epilepsy	☐ ☐ Seizure Disorder	☐ ☐ Hemophilia	☐ ☐ Coronary Artery Disease
☐ ☐ Stroke	☐ ☐ Sickle Cell Disease	☐ ☐ Bleeding Disorder	☐ ☐ Heavy Metal Poisoning

Surgical Treatment [Please check the appropriate box. Each illness/injury requires a Yes (Y) or No (N) answer.] For each Yes (Y) answer, please complete the information corresponding to the surgery on the right. Additional information can be provided on the Explanation Page, if necessary.

Y N

☐ ☐ Spinal Disc Surgery — Year (approximate if unsure)_____

☐ ☐ Spinal Fusion Surgery — Year (approximate if unsure)_____

☐ ☐ Amputated Foot — Left ☐ Right ☐ Year (approx. if unsure) _____

☐ ☐ Amputated Leg — Left ☐ Right ☐ Year (approx. if unsure) _____

☐ ☐ Amputated Arm — Left ☐ Right ☐ Year (approx. if unsure) _____

☐ ☐ Amputated Hand — Left ☐ Right ☐ Year (approx. if unsure) _____

☐ ☐ Knee Replacement — Left ☐ Right ☐ Year (approx. if unsure) _____

☐ ☐ Hip Replacement — Left ☐ Right ☐ Year (approx. if unsure) _____

☐ ☐ Other Joint Replacement — Joint _____ Year _____

☐ ☐ Other Surgical Procedure — Procedure _____ Year _____

☐ ☐ Other Surgical Procedure — Procedure _____ Year _____

☐ ☐ Other Surgical Procedure — Procedure _____ Year _____

☐ ☐ Other Surgical Procedure — Procedure _____ Year _____

Employee Signature:_____ Date: _____

Employer Representative: _____ Date: _____

EXPLANATION PAGE

Please use the space below to explain the illnesses and/or conditions that you checked a Yes (Y) or any other medical conditions that may not be listed on this form. Ask your employer for additional copies of this page if needed.

CONDITION: ______________________________ Year Diagnosed (approx): __________

Are you still treating for this condition? Yes ☐ No ☐

Are you taking medication for this condition? Yes ☐ No ☐

Do you have any permanent restrictions for this condition? Yes ☐ No ☐

Brief Explanation: ______________________________

____

CONDITION: ______________________________ Year Diagnosed (approx): __________

Are you still treating for this condition? Yes ☐ No ☐

Are you taking medication for this condition? Yes ☐ No ☐

Do you have any permanent restrictions for this condition? Yes ☐ No ☐

Brief Explanation: ______________________________

____

CONDITION: ______________________________ Year Diagnosed (approx): __________

Are you still treating for this condition? Yes ☐ No ☐

Are you taking medication for this condition? Yes ☐ No ☐

Do you have any permanent restrictions for this condition? Yes ☐ No ☐

Brief Explanation: ______________________________

____

CONDITION: ______________________________ Year Diagnosed (approx): __________

Are you still treating for this condition? Yes ☐ No ☐

Are you taking medication for this condition? Yes ☐ No ☐

Do you have any permanent restrictions for this condition? Yes ☐ No ☐

Brief Explanation: ______________________________

____

Employee Signature: ______________________________ Date: ______________

Employer Representative: ______________________________ Date: ______________

Please answer the following questions.

1. Has any doctor ever restricted your activities? Yes ☐ No ☐
   If "Yes," please list the restrictions: _____
   Were the restrictions: Permanent ☐ Temporary ☐
   Are your activities currently restricted? Yes ☐ No ☐
   What is the medical condition for which you have restrictions? _____

2. Are you presently treating with a doctor, chiropractor, psychiatrist, psychologist or other health-care provider? Yes ☐ No ☐

   Please list the medical condition being treated: _____

   Doctor's Name: _____ Specialty: _____

   Doctor's Address: _____

3. If you are currently taking prescription medication other than those listed on the Explanation Page, please complete the requested information below.

   Medication: _____ Prescribing Doctor: _____

   Medication: _____ Prescribing Doctor: _____

4. Have you ever had an on the job accident? Yes ☐ No ☐
   If you answered "YES," please provide the date for each injury and the nature of the injury:

   _____

   How long were you on compensation? _____

   Name of Employer: _____

5. Has a doctor recommended a surgical procedure, which has not been completed prior to this date, including but not limited to knee, hip or shoulder replacement? Yes ☐ No ☐
   If you answered YES, please provide:

   Recommended surgery: _____

   Approximate date of recommendation: _____

   Doctor's Name: _____ Specialty: _____

   Doctor's Address: _____

Employee Signature: _____ Date: _____

Employer Representative: _____ Date: _____

TO BE COMPLETED BY EMPLOYEE

EMPLOYEE WARNING

FAILURE TO ANSWER TRUTHFULLY AND/OR CORRECTLY TO ANY OF THE QUESTIONS ON THIS FORM MAY RESULT IN A FORFEITURE OF ANY AND ALL WORKERS COMPENSATION BENEFITS UNDER La. R.S. 23:1208.1.

I have completed this form honestly and to the best of my knowledge. I understand that providing false information or omitting pertinent information could result in loss of my workers compensation benefits should I become injured on the job.

Employee Signature:_____ Date: _____

Employee Printed Name: _____

TO BE COMPLETED BY EMPLOYER REPRESENTATIVE

EMPLOYER WARNING

PURSUANT TO La. R.S. 23:1208 OF THE LOUISIANA WORKERS' COMPENSATION ACT, IT SHALL BE UNLAWFUL FOR A PERSON, FOR THE PURPOSE OF OBTAINING OR DEFEATING ANY BENEFIT PAYMENT UNDER THE PROVISIONS OF THIS CHAPTER, EITHER FOR HIMSELF OR FOR ANY OTHER PERSON, TO WILLFULLY MAKE A FALSE STATEMENT OR REPRESENTATION. PENALTIES FOR VIOLATIONS INCLUDE IMPRISONMENT, FINES, AND/OR THE FORFEITURE OF BENEFITS.

You must certify the following:

1. That I am an authorized representative of the employer designated to obtain and review the information provided by the employee on this questionnaire;

2. That I have provided the employee with as many copies of the Explanation Page as needed and have confirmed the number of and labeled the pages of this questionnaire;

3. That I have provided assistance to the employee (if requested) in responding to the questions on this questionnaire;

4. That the information sought by this authorization is made on an applicant for employment only after a conditional job offer has been made and accepted, or on a current employee; and

5. That the information obtained in the authorization will **NOT** be used to discriminate in any manner against the individual who is the subject of this authorization on any basis, in violation of the Americans with Disabilities Act of 1990, 42 U.S.C. §12101, *et seq.*, or any other state or federal law;

6. That if requested, a photocopy of this fully completed and signed form will be provided to the employee.

Employer Representative Signature:_____ Date: _____

Employer Representative Printed Name:_____

Title: _____