ATTACHMENT C

RESPONDENT'S ARGUMENT

Submission Respondents Arguement. (I) December 1, 2015
Erlinda Velasquez Respondent
Case No. 2013-0081 OAH No 2014040788
Hearing Oakland 10-15-15 Judge Jill Schlichtmann

I Erlinda Velasquez hereby appeal the proposed decision
of the Judge in above-named matter. Calpers takes
Formal Action to either adopt it remand it or decline
to adopt it in favor of its own Decision. On Sept 25, 2009
The basis for the appeal is that the decision is unsupported
by the evidence at hearing held oct 15, 2015. Judge Jill Schlichtmann
stated That I was terminated Because of a wage garnishment
on Behalf of my Nephew on the Arbitrator William Reimer
Decision. See attached letter submitted By my attorney
Steven Paul Cohn whom I hired to represent me.
Letter Dated may 21, 2010 Also My Unemployment
Insurance Claim Dated 8/30/2010 Time 9:01:57 Am
Also The Bankruptcy in Question Regarding Jesse
Velasquez was in fact filed on Sept 25, 2009, See
attached claim of Exemption Levying Officer File No 09-787614
Court Case No 5-09-CV-003594 stamped date by Clerk
Office Civil Section Santa Clara County 2009, Sept 25, at 12:52 pm
Along with a Notice of Termination order From the attorney
Thomas Caudill stating that the Earnings withholding order
is terminated. Therefore Arbitrator Recommendation
was to only Suspend me For 5 months and Be reinstated
to my Job at San Jose/Evergreen Valley College District For
over 10 yrs with No Disciplinary record on File. Also
I had applied For Calpers Disability on December 15, 2010
See Copy of Disability Retirement Application 19 full pages Completed
By my Doctor Marvin Masada also Notarized Do to Being
Divorced on 1/23/2009 see attached Domestic Absence Sparse.
Also I had Requested a Cost Service Credit Record by my

December 1, 2015

my Ex-employer
San Jose-Evergreen Community College Dist. They received Stamped Dated
4750 San Felipe Rd
San Jose, CA 95135

it Jan 25, 2011. BUT my Signature and Dated 12/10/201
So I ask that the Board please review all
My Direct Evidence. TO Review and The Board has
the power to give my case Erlinda Velasquez a -
Reconsideration of my Cal-Pers Disabity application
TO be approved. I am currently Disabled. From
Social Secuty. My Docter Jeffrey D. Livingston-Carr MD
wrote a Letter on my Behalf see attached Doement Dated
July 8 2011. I ask the Board to consider all
My evidence and grant me an approved cal-Pers
Dischrt. I am a Single mother of two children
a Daughter 14 yrs old and a Son 20 yrs..

Thank you For allowing me to Submit my Respondet
argument.

Erlinda Velasquez December 1, 2015

Dedicated to the Health of the Whole Community

SANTA CLARA VALLEY HEALTH & HOSPITAL SYSTEM
DEPARTMENT OF MENTAL HEALTH

Josefa Chaboya Narvaez
Mental Health Center
614 Tully Road
San Jose, California 95111
Tel. (408) 494-1561
Fax. (408) 292-3640

July 8, 2014

RE: Velasquez, Erlinda, DOB

To Whom It May Concern,

This letter is being written to document Ms. Velasquez's diagnoses and treatment. She has been a patient at our clinic since 2011, and I have been her treating physician since 2013. She is seen here monthly or more often as needed. She is diagnosed with Major Depressive Disorder, Mood Disorder NOS, and Anxiety Disorder. She is currently disabled as a result of her psychiatric illness and is unable to perform her past duties as a payroll technician. Her current medications are Abilify 20 mg daily, fluoxetine 40 mg daily, trazodone 150 mg qhs, and lorazepam 0.5 mg PRN. Please do not hesitate to contact me if you have any questions regarding Ms. Velasquez.

Sincerely,

Jeffrey D. Livingston-Carr, MD

Santa Clara Valley Health and Hospital System

Narvaez Behavioral Health

614 Tully Road

San Jose, CA 95111

Phone [408] 494-1561

Fax [408] 292-3640

STEVEN PAUL COHN
ADVOCACY CENTER FOR EMPLOYMENT LAW
2084 Alameda Way
San Jose, California 95126
(408) 557-0300
Fax: (408) 557-0309

May 21, 2010

VIA U.S. MAIL

California Unemployment Insurance Appeals Board
San Jose Office of Appeals
2665 North First Street, Suite 100
San Jose, CA 95134

Re: **Erlinda Velasquez vs. San Jose/Evergreen Community College District**
Employer Account No. ; Case No. 3155879
Claimant SSN

Dear CUIAB Office of Appeals:

This office represents Appellant Erlinda Velasquez who hereby appeals the Decision of May 4, 2010 of Administrative Law Judge Douglas Bird in the above-captioned matter.

The basis for the appeal is that the decision is unsupported by the evidence at hearing. Specifically, the Board found that there was a knowing misrepresentation by Ms. Velasquez in representation to the Sheriff (a garnishment-levying officer), that a relative's claim was subject to a bankruptcy. There was a finding of willfulness against Appellant. The evidence demonstrates, however, that Appellant did not represent, and had not confirmed the pendency of a bankruptcy, but had merely listed the bankruptcy attorney's name and number, as had been reported by this "relative", such that the levying officer could confirm same itself. Additionally, the District thereafter failed to return the levying documentation to the attorney representing the creditor, who was garnishing the "relative's" wages.

It was additionally established that this "relative" was the employee who ordinarily handled wage garnishments for the District, and only passed this over to Appellant Velasquez to do when Appellant was directed to attend to this by her management. Appellant had not performed a garnishment in approximately one year, while the management representative testifying on behalf of the employer conceded that he had no particular experience with this, had not seen or published any protocols concerning this prior to this event, that he was aware of no established protocols precluding Appellant's conduct herein, and that these practices were modified only after this event, such that Appellant did not violate any regulations in doing what she did.

It was further established, by direct testimony of the "relative", Jesse Velasquez, that Mr. Velasquez was the **PRESIDENT** of the relevant employee's union, was a reliable source for confirming that the matter was subject to a bankruptcy filing for him, and that he believed that the bankruptcy had in fact been filed, but because he did not have confirmation of the court number, Ms. Velasquez listed Mr. Velasquez' attorney's name and number for direct confirmation by the

levying officer. Had the District properly returned the Acknowledgment to the attorney having issued the garnishment, as management, not Ms. Velasquez, was required to do, the matter would have been quickly rectified.

The District further established that there were no conflict of interest rules precluding the processing of garnishment orders for nephews, as was the case here, while the familial relationship has long been known by the very supervisor who directed Ms. Velasquez to accept service of the garnishment in lieu of Jesse Velasquez, the District's ordinary agent for accepting service of wage garnishments.

Request is hereby made to supplement the basis of appeal with the transcribed record of testimony before Judge Bird, once that has been made available. This transcript has been ordered and will be transcribed by a registered Certified Court Reporter and Notary, with the original transcript to be lodged with the Board upon receipt.

Thank you for your courtesy and attention.

Yours very truly,

SPC

STEVEN P. COHN, ESQ.
Attorneys for Erlinda Velasquez, Appellant
pc: client

ATTORNEY OR PARTY WITHOUT ATTORNEY (Name and Address):	TELEPHONE NO.:	LEVYING OFFICER (Name and Address):
Jesse Velasquez 101 Gordon Ave SJ. CA 95127	(408) 921-1232	SHERIFF SANTA CLARA COUNTY 55 W. YOUNGER AVE. SAN JOSE, CA 95110 ATTN: CIVIL SECTION
ATTORNEY FOR (Name):		
NAME OF COURT, JUDICIAL DISTRICT OR BRANCH COURT, IF ANY: Superior Santa Clara South County Civil Unit		
PLAINTIFF: Santa Clara City Federal C.U.		
DEFENDANT: Jesse S. Velasquez		
CLAIM OF EXEMPTION **(Wage Garnishment)**	LEVYING OFFICER FILE NO.: 09-787614	COURT CASE NO.: 5-09-CV-003594

—READ THE EMPLOYEE INSTRUCTIONS BEFORE COMPLETING THIS FORM—

Copy all the information required above (except the top left space) from the Earnings Withholding Order. The top left space is for your name or your attorney's name and address. The original and one copy of this form with the Financial Statement attached must be filed with the levying officer. DO NOT FILE WITH THE COURT.

1. I need the following earnings to support myself or my family *(check a or b)*:
   a. [X] All earnings.
   b. [ ] $ _____ each pay period.

2. Please send all papers to
   [X] me.
   [ ] my attorney
   at the address [X] shown above [ ] following *(specify)*:

SHERIFF'S DEPT.
CIVIL SECTION
SANTA CLARA COUNTY
2009 SEP 25 PM 12:52

3. I am willing for the following amount to be withheld from my earnings each pay period during the withholding period. **I understand that the judgment creditor can accept this offer by not opposing the Claim of Exemption, which will result in the following sum being withheld each pay period** *(check a or b)*:
   a. [ ] None
   b. [X] Withhold $ 200.00 each pay period.

4. I am paid
   [ ] daily [ ] every two weeks [X] monthly
   [ ] weekly [ ] twice a month [ ] other *(specify)*:

NOTE: ***You must attach a properly completed Financial Statement form to this Claim of Exemption.*** The Financial Statement form is available without charge from the levying officer.

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

Date: 9-25-09

Jesse Velasquez
(TYPE OR PRINT NAME)

Jesse S Velasquez
(SIGNATURE OF DECLARANT)

WG-012

ATTORNEY OR PARTY WITHOUT ATTORNEY (Name, State Bar number, and address):	TELEPHONE NO:-	LEVYING OFFICER (Name and Address)
Thomas Caudill **1025 N.Fourth St** **San Jose, CA 95112**	**(408) 298-4844**	**Santa Clara County Sheriff's Office** **Office of the Sheriff-Civil Division** **55 W Younger Ave** **San Jose, CA 95110** **(408) 808-4800** **Fax: (408) 998-0636** **California Relay Service Number** **(800) 735-2929 TDD or 711**
ATTORNEY FOR (Name): **Santa Clara County Federal Credit Union**		
NAME OF COURT, JUDICIAL DISTRICT, OR BRANCH COURT, IF ANY: **Santa Clara County Superior Court**		
PLAINTIFF: **Santa Clara County Federal Credit Union** DEFENDANT: **Jesse S Velasquez**		
NOTICE OF TERMINATION OR MODIFICATION OF EARNINGS WITHHOLDING ORDER	LEVYING OFFICER FILE NO.: **2009787614**	COURT CASE NO.: **509CV003594**

1. **TO EMPLOYER: You are given notice that the Earnings Withholding Order is modified as follows:**

Name and address of employer

San Jose-Evergreen Community College Dist
4750 San Felipe Rd
San Jose, CA 95135

Attn: **Payroll**

(Insert name above)

Name and address of employee

Jesse S Velasquez
101 Gordon Avenue
San Jose, CA 95127

Social Security Number *(if known)*: **(SSN Unknown)**

2. THE EARNINGS WITHHOLDING ORDER IS

a. [X] terminated for all earnings payable on or after *(date)*: **10/23/09**

b. [ ] modified for all earnings payable on or after *(date)*: as follows:

(1) [ ] The sum to be withheld is *(specify amount/weekly, monthly, etc.)*:
$
The amount withheld must not exceed the maximum permitted by law, as explained in the Employer's Instructions.

(2) [ ] The sum necessary for the support of the judgment debtor and family is *(specify amount/weekly, monthly, etc.)*:
$
All disposable earnings exceeding that amount are to be withheld, **but the amount withheld must not exceed the maximum permitted by law, as explained in the Employees Instructions.**

c. [ ] Other orders *(specify)*:

3. Withheld earnings presently in your possession should be paid in accordance with the terms of this notice.

Date: **10/30/2009**

Levying Officer, by **M. Flores** (TYPE OR PRINT NAME) [redacted] (SIGNATURE)

CREDITOR'S INSTRUCTION TO TERMINATE OR MODIFY EARNINGS WITHHOLDING ORDER

To the levying officer: You are directed to terminate or modify the Earnings Withholding Order as indicated above.

Date:

..... (TYPE OR PRINT NAME)

[redacted] (SIGNATURE)

Form Adopted by the Judicial Council of California
WG-012 [Rev. January 1, 2007]

NOTICE OF TERMINATION OR MODIFICATION OF EARNINGS WITHHOLDING ORDER (Wage Garnishment)

Code of Civil Procedure, §§ 706.105(f), 706.105
www.courtinfo.ca.gov

CONCERNING THE UNEMPLOYMENT INSURANCE CLAIM OF:

E VELASQUEZ

YOU PROVIDED INFORMATION REGARDING THE ELIGIBILITY OF THE CLAIMANT NAMED ABOVE UNDER CALIFORNIA UNEMPLOYMENT INSURANCE CODE (CUIC) SECTION 1256. WE HAVE CONSIDERED ALL OF THE AVAILABLE FACTS AND REACHED THE CONCLUSION STATED BELOW. PLEASE DO NOT RESUBMIT THE SAME ELIGIBILITY INFORMATION IN REPLY TO ANY FUTURE CLAIMS NOTICES. THIS DECISION IS FINAL UNLESS MODIFIED, RECONSIDERED, OR APPEALED.

YOU DISCHARGED THE CLAIMANT FOR NOT PERFORMING THE WORK TO YOUR SATISFACTION. AFTER CONSIDERING THE AVAILABLE INFORMATION, THE DEPARTMENT FINDS THE REASONS FOR DISCHARGE DO NOT MEET THE DEFINITION OF MISCONDUCT CONNECTED WITH THE WORK.

APPEAL:

YOU HAVE THE RIGHT TO FILE AN APPEAL IF YOU DO NOT AGREE WITH ALL OR PART OF THIS DECISION.

TO APPEAL, YOU MUST DO ALL OF THE FOLLOWING:

7-3

Employment Development Department
State of California

MC

RECORD OF CLAIM STATUS INTERVIEW MISCONDUCT (MC)

Date of Interview 12-02-09

1. **SSN:** _____ 2. **Claimant's Last Name:** VELASQUEZ (wp 10-12 noon)
3. **BYB:** 11-01-09 4. **Affected Week(s):** 11-07-09
5. **Potentially Disqualifying Facts:** MC Reason Falsely accused of processing a wage garnishment order
6. **Check If Applicable**

☐ Unscheduled Issue/Verbal Due Process Provided ☐ Information Only ☐ Pre-Appeal ☐ Re-Det

7. **Documents Made Part of Record**

☐ ER Pro Dated _____ ☒ 1173 Dated 11/01/09 ☐ Other _____

8. **ATTEMPTS TO REACH EMPLOYER/AGENT**

Er name: SAN JOSEEVERGREEN COMMUNI Agent Name _____

Phone No. ER 408-270-6412 Agent _____ Date 12/02/09 Time Called: 11:00 am

Results of Final Call:

☒ Reached ER/Agent ☐ Busy ☐ Disconnected/Wrong No. ☐ No Answer

Or Left Message:

☐ Answering Machine or
☐ with Name _____ Title _____

for ER/Agent to return call by Date _____ Time _____

☐ ER/Agent did not return call Date _____ Time _____ ☐ DE 4463 Suspense Date _____

9. **EMPLOYER/AGENT INFORMATION**

Spoke with

☒ ER
☐ Agent Name Marsila Disch Title HR Manager

Date 12.02/09 Time 11:00 am Clmt's. Job Title N/A
Duration N/A Rate of Pay $ N/A Per N/A

WHEN was clmt terminated? Date N/A **LDW** N/A

WHO terminated the clmt? Name N/A Title N/A

HOW was clmt terminated? ☐ In Person ☐ By Phone ☐ Other _____

WHY was clmt terminated? Document specific dates and facts of **FINAL INCIDENT**. Include dates of and reasons for warnings.
****Per Marsila Disch, er is not contesting benefits****

WAS clmt warned? ☐ Yes ☐ No If yes, document dates and reasons for warnings. N/A

WHAT reason was given to the clmt for the discharge? N/A

If none, **WHY NOT?** _____

If delay between the final incident and discharge, explain: N/A

10. **ATTEMPTS TO REACH CLAIMANT**

Phone No. 408 440 8695 Time Called 11:05 AM ☐ Will Call Time Clmt Called _____

Results of Final Call:

☒ Reached Clmt ☐ Busy ☐ Disconnected/Wrong No. ☐ No Answer

Or Left Message:

☐ Answering Machine or
☐ with a Responsible Party: Name _____ Relationship _____

☐ For clmt to refer to the Notice Of Appointment, DE 4800 and a decision will bases on available information.

☐ for clmt to return call by Date _____ Time _____ or decision will be made on available information.

Call returned?

☐ No as of Date _____ Time _____

☐ Or Yes, Date: _____ Time call returned: _____

☐ DE 4365 sent on: Date _____ Suspense date: _____ ☐ No response

11. CLAIMANT INFORMATION

☒ Verified last employer – Name SAN JOSE EVERGREEN COMMUNI

LDW 11/05/09 Job Title Payroll Tech

Duration 18 yrs Rate of Pay $ 27.00 Per hr

WHEN was clmt terminated? Date 11/05/09

WHO terminated the clmt? Name Jeanine Hawk Title Vice President

HOW was clmt terminated? ☐ In Person ☐ By Phone ☒ Other mail

WHY was clmt terminated? What reason(s) were given to the clmt? Include **FINAL INCIDENT** and date. 11/05/09 Clmt stated she was accused of processing a garnishment order. Clmt stated a Garnishment order came in and was for her nephew, clmt signed for the wage garnishment order. Clmt processed the order (meaning sending it out), but with consent of the mgr. Clmt stated that there was no conflict. Clmt stated there is no manual or training about processing garnishments for family members. Clmt sated she worked at the office for over 18 yrs and she never had any issues before. Clmt states that the process was done and sent to Anthony Owen, where it was mailed out to the sheriffs.

DID clmt know or should have known his/her actions could result in termination? ☐ Yes ☒ No If yes, Explain (i.e., dates/reasons for warnings, know er policy) _____

12. ATTEMPTS TO RESOLVE CONFLICTING INFORMATION OR OBTAIN INFORMATION FROM OTHER SOURCES:

☐ Clmt ☐ ER ☐ Other(Name /Title/Ph #): _____

Date called: _____ Time _____

Results of Final Call:

☐ Reached Clmt ☐ Busy ☐ Disconnected/Wrong No. ☐ No Answer

Or Left Message:

☐ On Machine or ☐ with a Responsible Party: Name _____ Title/Relationship _____

☐ To return call by: Date: _____ Time _____ or decision will be made on available information.

Call returned?

6-7

☐ No as of Date _____ Time _____

☐ Or Yes, Date: _____ Time call returned: _____

☐ DE 4463 or ☐ _____ sent on: Date _____ Suspense date: _____ ☐ No response

13. **SUMMARY OF MATERIAL FACTS AND REASON FOR DECISION:**

On 11/05/09 Clmt stated she was accused of processing a garnishment order. Er is not contesting benefits. Er had the material duty to show the burden of proof of misconduct. Due to no information received from er, there was no substantial breach of duty. Clmt is eligible for benefits under section 1256 because department could not find discharge for misconduct in connection of work.

LEGAL RESULTS Under Section 1256 of the UI Code clmt is ☒ MC Eligible ☐ MC Disqualified RD MC300-CC

ER/Agent Address 4750 SAN FELIPE RD SAN JOSE CA 95135 1510

ER Acct. No.

Decision Made On Date: 12/05/09 At Time: 7:10 am

Deanna Casas

Department Representative

Disability Retirement Election Application

888 CalPERS (or 888-225-7377) • TTY for Speech and Hearing Impaired: (916) 795-3240

Employer Information

☐ Check if this is an employer-originated application.
Employer must fill out and sign Section 12 on the last page of this application.

Application Type

☒ Disability Retirement
☐ Service Pending Disability Retirement
☐ Industrial Disablility Retirement
☐ Service Pending Industrial Disability Retirement

Section 1

Please provide your name as it appears on the Social Security card.

Please display all dates in this order: month/day/year.

Information About You

Erlinda Velasquez
Name of Member (First Name, Middle Initial, Last Name)

Social Security Number

Address

City

State

Birth Date (mm/dd/yyyy)

☐ Male ☒ Female
Gender

Home Phone

Work Phone

Section 2

Please do not abbreviate your employer or position.

Do not list Social Security, military or railroad retirement as a California public retirement system.

Retirement Information

01/04/2011
Retirement Date (mm/dd/yyyy)

San Jose/Evergreen Valley College District
Employer

Payroll Technician
Position Title

Do you have any final compensation period higher than the last consecutive 12 or 36 months?
☒ No ☐ Yes, from _____ to _____.
Beginning Date (mm/dd/yyyy) Ending Date (mm/dd/yyyy)

Are you a member of a California public retirement system other than CalPERS? ☐ No ☐ Yes, provide:

Name of System

Date of Retirement (mm/dd/yyyy)

Beginning Service Credit Date (mm/dd/yyyy)

Ending Service Credit Date (mm/dd/yyyy)

Section 3

Local safety members should not complete Sections 3 & 4.

Workers' Compensation Information

N/A
Workers' Compensation Carrier

Name of Adjuster

( )
Phone Number

Address

City

State

ZIP

Claim Number(s) Relating to Alleged Disability

Date of Injury (mm/dd/yyyy)

Put your name and Social Security number at the top of every page.

Erlinda Velasquez
Your Name

Social Security Number

Section 4

Disability Information

Please complete all the questions below. If you need additional space, attach separate sheets and be sure to include your name and Social Security number on all sheets.

What is your specific disability; when and how did it occur?

mental Distress anxiety Depression Disord
It started after I gave birth to my second child. I got Post Pardum Depression and was Sad therapy and was referred to a psychologist/psychiatrist medica

What is the complete name and address of your treating physician(s)?

Marvin Musada
Name of Treating Physician

Medical Record Number

1569 LeyAnn Avenue, suite 128
Address

San Jose | CA | 95121 | (408) 274-1654
City | State | ZIP | Phone Number

What are your limitations/preclusions due to your injury or illness?

Per Doctor Musada was unable to perform Duties and took me OFF work and was being therapy For Anxiety & Depression

How has your injury or illness affected your ability to perform your job?

Unable to follow orders directions.
Medication prevents me From being aware of Situations for daily living makes me drowsy and unsure Afraid to be around a lot of people anxiety.

Are you currently working in any capacity (full-time, part-time, or modified work)? If yes, please explain.

NO

Other information you would like to provide.

My Situation gotten worse after the Death of my Supervisor I got into a Deep depression and now I was put on Medication and Seeing Dr. Marvin Musada During this time

Did a third party cause your injury? ☒ No ☐ Yes (If yes, CalPERS has a potential "right of subrogation.")

Put your name and Social Security number at the top of every page.

Erlinda Velasquez
Your Name

Social Security Number

Section 5 — Select Your Retirement Payment Option and Beneficiary

Select only one payment option: Option 1, Option 2, Option 2W, Option 3, Option 3W, the Unmodified Allowance Option, or one of the Option 4 types.

By filling out this section, you are electing your Retirement Payment Option and designating your beneficiary. Once you select a payment option, you cannot change to another option. Along with your option selection, you must complete at least one of the beneficiary designations in Sections 5a-5d. If you choose the Unmodified Allowance Option, you do not need to specify a beneficiary. Please refer to the detailed instructions in this publication for more information.

☒ **Option 1** - To complete this option choice, you must also fill out Section 5d, *Balance of Contributions Beneficiary(ies).*

☐ **Option 2** - To complete this option choice, you must also fill out Section 5a, *Individual Lifetime Beneficiary.*

☐ **Option 2W** - To complete this option choice, you must also fill out Section 5a, *Individual Lifetime Beneficiary.*

☐ **Option 3** - To complete this option choice, you must also fill out Section 5a, *Individual Lifetime Beneficiary.*

☐ **Option 3W** - To complete this option choice, you must also fill out Section 5a, *Individual Lifetime Beneficiary.*

☐ **Unmodified Allowance Option** - If you select this option there is no return of your member contributions and no monthly benefits payable upon your death - except the Survivor Continuance benefit, if applicable. There is no beneficiary designation for this option.

These options apply to Option 4 Individual Lifetime Beneficiary only.

☐ **Option 4, Individual Lifetime Beneficiary** - If you select this option, you must also select one of the following Individual Lifetime Beneficiary options below.

- ☐ **Option 2W & Option 1** Combined - To complete this option choice, you must also fill out Section 5a *Individual Lifetime Beneficiary* and Section 5d *Balance of Contributions Beneficiary(ies).*
- ☐ **Option 3W & Option 1 Combined** - To complete this option choice, you must also fill out Section 5a *Individual Lifetime Beneficiary* and Section 5d *Balance of Contributions Beneficiary(ies).*
- ☐ **Specific Dollar Amount to Beneficiary** $_____ (Dollars) - To complete this option choice, you must also fill out Section 5a *Individual Lifetime Beneficiary*
- ☐ **Specific Percentage to Beneficiary** _____ (Percent)% - To complete this option choice, you must also fill out Section 5a *Individual Lifetime Beneficiary*
- ☐ **Reduced Allowance for Fixed Period of Time** _____ (Percent or Dollars) **through** _____ (Date (mm/yyyy)).
- ☐ **Reduced Allowance upon death of retiree or beneficiary:** $_____ (Dollars) **reduction amount**

  If you are naming a beneficiary under this option, you must also fill out Section 5a, *Individual Lifetime Beneficiary.*

This option applies to Option 4 Multiple Lifetime Beneficiaries only.

☒ **Option 4, Multiple Lifetime Beneficiaries** - To complete this option choice, you must also fill out Section 5b *Option 4 Multiple Lifetime Beneficiaries.*

These options apply to Option 4, Court Ordered Community Property only.

☐ **Option 4, Court Ordered Community Property** - If you select this option, you must also complete Section 5c, *Court Ordered C.P. Beneficiary* and select one of the following Court Ordered Option 4 Community Property options.

- ☐ **Option 4/Unmodified** - There is no additional beneficiary designation for this option.
- ☐ **Option 4/1** - To complete this option choice, you must also fill out Section 5d, *Balance of Contributions Beneficiary(ies).*
- ☐ **Option 4/2W** - To complete this option, you must also fill out Section 5a, *Individual Lifetime Beneficiary.*
- ☐ **Option 4/3W** - To complete this option, you must also fill out Section 5a, *Individual Lifetime Beneficiary.*

Put your name and Social Security number at the top of every page.

Erlinda Velasquez
Your Name

Social Security Number

Section 5a

Designate one beneficiary and provide all of that person's information including full name.

Option 2, 2W, 3, 3W or 4 Individual Lifetime Beneficiary

Complete this section only if you chose either Option 2, 2W, 3, 3W or Option 4 Individual Lifetime Beneficiary or Option 4/2W or 4/3W Court Ordered Community Property.

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

Birth Date (mm/dd/yyyy) | ☐ Male ☐ Female Gender | Relationship to You

Address

City | State | ZIP | Country

Section 5b

If you want your beneficiaries to receive an equal share of your benefits, do not specify a dollar or percentage of benefit.

Option 4 Multiple Lifetime Beneficiaries

Complete this section only if you selected Option 4 Multiple Lifetime Beneficiaries.

Joel Salvador Sanchez
Name (First Name, Middle Initial, Last Name) | Social Security Number

Birth Date (mm/dd/yyyy) | ☑ Male ☐ Female Gender | Son Relationship to You | Dollar/Percent of Benefit

Address

City | State | ZIP | Country

Maria-Alicia Sanchez
Name (First Name, Middle Initial, Last Name) | Social Security Number

Birth Date (mm/dd/yyyy) | ☐ Male ☑ Female Gender | Daughter Relationship to You | Dollar/Percent of Benefit

Address

City | State | ZIP | Country

Salvador DeJesus Sanchez
Name (First Name, Middle Initial, Last Name) | Social Security Number

Birth Date (mm/dd/yyyy) | ☑ Male ☐ Female Gender | Childrens Father Relationship to You | Dollar/Percent of Benefit

Address

City | State | ZIP | Country

Section 5c

List only the Option 4 beneficiary that is required by your court order.

Court Ordered Option 4 Community Property Beneficiary

Complete this section only if you selected Option 4 Court Ordered Community Property.

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

Birth Date (mm/dd/yyyy) | ☐ Male ☐ Female Gender | Relationship to You

Address

City | State | ZIP | Country

Put your name and Social Security number at the top of every page.

Erlinda Velasquez
Your Name

Social Security Number

Section 5d

Designate up to three beneficiaries here. If you want to designate more than three beneficiaries. See page 23 for information on completing the ***Lump Sum Beneficiary Designation*** form.

Option 1 Balance of Contributions Beneficiary(ies)

Complete this section only if you selected Option 1, Option 4-2W/1 or 3W/1 combined. You may change this beneficiary(ies) at any time. This designation automatically revokes when there is a change in your marital status, domestic partnership status, or when there is a birth or adoption of a child. Please refer to the detailed instructions in this publication for more information.

Joel Salvador Sanchez
Name (First Name, Middle Initial, Last Name)

Social Security Number

Birth Date (mm/dd/yyyy)

☒ Male ☐ Female
Gender

Son
Relationship to You

Address

City

State

ZIP

Country

Maria-Alicia Sanchez
Name (First Name, Middle Initial, Last Name)

Social Security Number

Birth Date (mm/dd/yyyy)

☐ Male ☒ Female
Gender

Daughter
Relationship to You

Address

City

State

ZIP

Country

Name (First Name, Middle Initial, Last Name)

Social Security Number

Birth Date (mm/dd/yyyy)

☐ Male ☐ Female
Gender

Relationship to You

Address

City

State

ZIP

Country

Section 6

All Applicants must complete this section.

Designate your beneficiary to receive your lump sum Retired Death Benefit.

Retired Death Benefit

This section designates the person who will receive your lump sum Retired Death Benefit. You may change this beneficiary(ies) at any time. This designation automatically revokes when there is a change in your marital status, domestic partnership status, or when there is a birth or adoption of a child. Please refer to the detailed instructions in this publication for more information.

Joel Salvador Sanchez
Name (First Name, Middle Initial, Last Name)

Social Security Number

Birth Date (mm/dd/yyyy)

☒ Male ☐ Female
Gender

Son
Relationship to You

Address

City

State

ZIP

Country

Section 6 continues on page 6

Put your name and Social Security number at the top of every page.

Your Name: Erlinda Velasquez

Social Security Number:

Section 6, continued — Retired Death Benefit

All Applicants must complete this section.

Designate your beneficiary to receive your lump sum Retired Death Benefit.

Name (First Name, Middle Initial, Last Name): Maria-Alicia Sanchez

Social Security Number:

Birth Date (mm/dd/yyyy): ☐ Male ☑ Female Gender: Daughter Relationship to You

Address:

City: State: Zip: Country:

Name (First Name, Middle Initial, Last Name): Salvador DeJesus Sanchez

Social Security Number:

Birthdate (mm/dd/yyyy): ☑ Male ☐ Female Gender: Father of my two kids have been married Relationship to You

Address:

City: State: ZIP: Country:

Section 7 — Survivor Continuance

Please answer all five questions and complete the information in each section where you answered "Yes."

Please refer to the detailed instructions in this publication for more information.

1. Will you be married on or before your disability retirement date? ☒ No ☐ Yes, provide:

Name of Spouse (First Name, Middle Initial, Last Name): Salvador DeJesus Sanchez

Social Security Number:

Birth Date (mm/dd/yyyy): ☑ Male ☐ Female Gender: Date of Marriage: 11-8-1994 to 1-23-2009 Stopped living together

2. Will you be registered with the California Secretary of State as being in a domestic partnership on or before your disability retirement date? ☐ No ☐ Yes, provide:

Name of Domestic Partner (First Name, Middle Initial, Last Name): Social Security Number:

Birth Date (mm/dd/yyyy): ☐ Male ☐ Female Gender: Date of Registered Partnership (mm/dd/yyy)

3. Do you have any natural or adopted children under age 18 who have never been married?
☐ No ☑ Yes, provide:

Name of Child (First Name, Middle Initial, Last Name): Joel Salvador Sanchez Social Security Number: Birth Date (mm/dd/yyyy):

Name of Child (First Name, Middle Initial, Last Name): Maria-Alicia Sanchez Social Security Number: Birth Date (mm/dd/yyyy):

4. Do you have any children who have never been married and were disabled prior to their 18th birthday and who are still disabled? ☑ No ☐ Yes, provide:

Name of Child (First Name, Middle Initial, Last Name): Social Security Number: Birth Date (mm/dd/yyyy)

Name of Child (First Name, Middle Initial, Last Name): Social Security Number: Birth Date (mm/dd/yyyy)

5. Are your parents dependent upon you for one-half of their support? ☐ No ☐ Yes, provide:

Name of Parent (First Name, Middle Initial, Last Name): Social Security Number: Birth Date (mm/dd/yyyy)

Name of Parent (First Name, Middle Initial, Last Name): Social Security Number: Birth Date (mm/dd/yyyy)

Put your name and Social Security number at the top of every page.

Erlinda Velasquez
Your Name

Social Security Number

Section 8 Last Day on Payroll

Please enter the last day you received compensation. 11-6-2009
Last Day on Payroll (mm/dd/yyyy)

Section 9 Employer Certification (For service pending applications only)

Have your employer complete this section.

Please refer to the detailed instructions in this publication for more information.

Employee's Last Day on Payroll (mm/dd/yyyy) | Employee's Separation Date (mm/dd/yyyy)

Do not detach from application.

Balance of unused sick leave hours on employee's date of separation _____ Hours ÷ 8 = _____ Days

Balance of educational leave hours on employee's date of separation _____ Hours ÷ 8 = _____ Days

This certification is not required if you were separated from employment more than four months ago.

By signing below, you hereby certify, under the penalty of perjury, that the above information is true, complete, and correct to the best of your knowledge. Any changes to this information must be submitted on an *Amended Employer Certification* form.

Signature of Employer | Print Name (First Name, Middle Initial, Last Name)

Position Title of Employer | Phone Number of Employer ( ) | Date (mm/dd/yyyy)

Section 10 Tax Withholding Election

Do not complete for industrial disability retirement.

Federal Income Tax information. Please refer to the detailed instructions in this publication for more information.

Please choose one only.

☒ Do not withhold federal income tax.

☐ Withhold federal income tax in the amount of $_____ Dollars per month.

☐ Withhold federal income tax based on the tax tables for:

- ☐ **A married individual with _____ Number tax withholding exemptions.**
- ☐ **A single individual with _____ Number tax withholding exemptions.**

In addition to the amount withheld based on the tax tables, withhold $_____ Dollars per month.

State withholding is optional for out-of-state residents.

State Income Tax information. Please refer to the detailed instructions in this publication for more information.

☒ Do not withhold State of California income tax.

☐ Withhold State of California income tax in the amount of $_____ Dollars per month.

☐ Withhold State of California income tax based on the tax tables for:

- ☐ **A married individual with _____ Number tax withholding exemptions.**
- ☐ **A single individual with _____ Number tax withholding exemptions.**

In addition to the amount withheld based on the tax tables, withhold $_____ Dollars per month.

☐ Withhold State of California income tax in the amount of 10 percent of the federal income tax withholding amount.

Workers' Compensation Carrier Request

888 CalPERS (or 888-225-7377) • TTY for Speech and Hearing Impaired: (916) 795-3240 • Fax: (916) 795-1280

Section 1 — Member Information

You must complete the front side of this form, sign, date and forward to your workers' compensation insurance carrier.

If you have filed a workers' compensation claim for the illness or injury directly related to the application for disability or industrial disability retirement, this *Workers' Compensation Carrier Request* form (reverse side) must be completed by your employer's workers' compensation insurance carrier.

N/A
Name of Member (First Name, Middle Initial, Last Name) | Social Security Number

Employer Name

Claim Number 1 | Date (mm/dd/yyyy) | Body Part(s)

Claim Number 2 | Date (mm/dd/yyyy) | Body Part(s)

Claim Number 3 | Date (mm/dd/yyyy) | Body Part(s)

Claim Number 4 | Date (mm/dd/yyyy) | Body Part(s)

Section 2 — Authorization to Release Information

Send this form directly to your workers' compensation insurance carrier. They will complete the reverse side of this form and send the requested information to CalPERS.

I have submitted an application for disability or industrial disability retirement with the California Public Employees' Retirement System (CalPERS). You are hereby authorized to furnish CalPERS, or its representative, any and all information, including photocopies of records in your possession, which CalPERS requires solely to assist in determining my physical or mental condition, illness, or disability. The purpose of this authorization is to assist CalPERS in determining my right to retirement or reinstatement under the Retirement Law pursuant to Government Code Sections 20128; and no other purpose. This authorization shall be valid for four years from the date shown below. A photographic copy of this authorization shall be as valid as the original.

Signature of Member | Date (mm/dd/yyyy)

This form continues on the back.

Put your name and Social Security number at the top of every page.

Erlinda Velasquez
Your Name

Social Security Number

Section 2 (continued) Physical Requirements, continued

Indicate with a check mark (✓) the frequency required for each activity listed at the right.

If there is not enough space to enter all your additional requirements or comments, attach a separate sheet. Be sure to use a label, or clearly write your name and Social Security number on each attachment.

Activity	Never	Occasionally Up to 3 hours	Frequently 3–6 hours	Constantly Over 6 hours	Distance/ Height
Walking on uneven ground					
Driving					
Working with heavy equipment					
Exposure to excessive noise					
Exposure to extreme temperature, humidity, wetness					
Exposure to dust, gas, fumes, or chemicals					
Working at heights					
Operation of foot controls or repetitive movement					
Use of special visual or auditory protective equipment					
Working with bio-hazards (e.g., blood-borne pathogens, sewage, hospital waste, etc.)					

Section 3 Signature of Employer and Member

This form must be completed and signed by you and your employer and sent to a medical specialist along with other documentation.

The medical specialist must be the treating physician specializing in your disabling condition.

If you are a Disability Retirement Election applicant, your employer must provide you a copy of this completed form. Your employer must send the signed original to CalPERS.

Also, you must attach your current job description/job duty statement and a copy of the *Physical Requirements of Position/Occupational Title* form to the *Physician's Report on Disability* form prior to sending them to a medical specialist. Complete document submittal requirements are described in *A Guide to Completing Your CalPERS Disability Retirement Election Application.*

If you are a Request to Work While Receiving Disability/Industrial Disability Benefits applicant, you must attach the job description/job duty statement of the prospective job to a copy of the completed *Physical Requirements of Position/Occupational Title* form prior to sending them to a medical specialist. You must submit the resulting medical report and other required documents to CalPERS. The *Physician's Report on Disability* form is not required. Complete document submittal requirements are described in *A Guide to CalPERS Employment After Retirement.*

Signature of Employer Representative — Date (mm/dd/yyyy)

Title — ( ) Phone Number

Signature of Member — ( ) Phone Number — Date (mm/dd/yyyy)

Mail to: **CalPERS Benefit Services Division** • P.O. Box 2796, Sacramento, California 95812-2796

Put your name and Social Security number at the top of every page.

Erlinda Velasquez
Your Name

Social Security Number

Section 11 Member Signature and Notary

This section must be completed or your application will be returned.

If your spouse's or domestic partner's signature is not available, See instructions in this booklet on completing the Justification for Absence of Signature form. Your signature and your spouse's or domestic partner's signature must be notarized by a notary public or witnessed by a CalPERS representative.

I certify, under the penalty of perjury, that the information submitted hereon is true and correct to the best of my knowledge. I understand to cancel this application or to change the elected option or beneficiary I must notify CalPERS before the mailing of my first full monthly retirement allowance check.

I understand that if I am married or in a registered domestic partnership, but do not name my spouse or partner as beneficiary, they may still be entitled to a community property share of the Option 1 lump sum return of contributions benefit **or** a share of the monthly option death benefit allowance. Their community property interest is 50% of the benefit based on the contributions or service credit earned for the period of CalPERS service during which we were married or in a registered partnership. My non-spouse or non-partner designated beneficiary will receive the portion of the lump sum Option 1 benefit or monthly option allowance that is not payable to my spouse or domestic partner. I understand that my spouse or domestic partner will have the right to disclaim entitlement to their community property interest in the death benefit at the time the benefit becomes payable, if they so desire.

More detailed information on this section is available in this publication.

Are you legally married or do you have a legal domestic partner? ☐ Yes ☒ No

If yes, your spouse or domestic partner must sign this election.

If no, please indicate: ☐ Never Married/or in Partnership ☐ Divorced/Annulled ☐ Widowed Or Termination of Domestic Partnership

Your Signature — Date (mm/dd/yyyy): 01/04/2011

Your Spouse's or Domestic Partner's Signature — Date (mm/dd/yyyy)

State of California, County of Santa Clara

On January 4, 2011 (Date) before me, Sarah Valencia, Notary Public (Name of Notary/Witness)

personally appeared Erlinda Velasquez, who proved to me on the basis of satisfactory evidence to be the person(s) whose name(s) is/~~are~~ subscribed to the within instrument and acknowledged to me that ~~he/she/they~~ executed the same in ~~his/her/their~~ authorized capacity(~~ies~~), and that by ~~his/her/their~~ signature(~~s~~) on the instrument the person(~~s~~), or the entity upon behalf of which the person(~~s~~) acted, executed the instrument.

I certify under **Penalty of Perjury** under the laws of the State of California that the foregoing paragraph is true and correct.

SARAH VALENCIA
Commission # 1766152
Notary Public - California
Santa Clara County
My Comm. Expires Sep 8, 2011

Notary Seal

Witness my hand and official seal **or** authorized CalPERS representative signature.

Sarah Valencia — Signature of Notary or CalPERS Representative

NOTARY PUBLIC — Position Title

01/04/2011 — Date (mm/dd/yyyy)

SARAH VALENCIA — Print Name

CalPERS Office (if applicable)

Section 12 Employer-Originated Application

To be completed if the employer is submitting the application on behalf of the member.

Signature of Employer

Print Name of Employer

Position Title of Employer — ( ) Phone Number — Date (mm/dd/yyyy)

Mail to: **CalPERS Benefit Services Division** • P.O. Box 942711, Sacramento, California 94229-2711

Justification for Absence of Spouse's or Domestic Partner's Signature

888 CalPERS (or 888-225-7377) • TTY for Speech and Hearing Impaired: (916) 795-3240

This form is to be used with the Retirement Election Application

Section 1 — Member Information

Please include the month, day and year for all dates as follows: mm/dd/yyyy.

Name of Member (First Name, Middle Initial, Last Name) _____ Social Security Number _____

Pursuant to Government Code Section 21261, the member's current spouse or legally recognized domestic partner must be made aware of the selection of benefits or change of beneficiary made by a member. The spouse or domestic partner of a CalPERS member must acknowledge the submission of: a request for refund of contributions, election of retirement optional settlement, and designation of beneficiary for retirement death benefits.

If a spouse or registered domestic partner's signature does not appear on one of the above-named documents, the following information must be completed by the member and submitted with the application for retirement.

Select either 1 or 2 and indicate specifics:

1. ☒ By checking this box, you indicate that you are not legally married or in a legal domestic partnership because:

   - ☐ Never married or never in legal domestic partnership.
   - ☒ Divorced/marriage annulled or domestic partnership terminated. 1-23-09 (Date (mm/dd/yyyy))
   - ☐ Widowed. _____ (Date (mm/dd/yyyy))

2. ☐ By checking this box, you indicate that you are married or have a registered domestic partner, but your spouse or domestic partner did not sign this form because:

   - ☐ You do not know and have taken all reasonable steps to determine the whereabouts of your spouse or domestic partner.
   - ☐ Your spouse or domestic partner has been advised of the application and has refused to sign the acknowledgment.
   - ☐ Your spouse or domestic partner is incapable of executing the acknowledgment because of an incapacitating mental or physical condition.
   - ☐ Your spouse or domestic partner has no identifiable community property interest in the benefit.
   - ☒ Your spouse or domestic partner and you have executed a marriage settlement or partnership agreement that makes the community property law inapplicable to the marriage or partnership.

Section 2 — Information Certification

You hereby certify under the penalty of perjury that the foregoing information is true and correct.

Signature of Member _____ Date (mm/dd/yyyy) 12-15-2010

Mail to: **CalPERS Benefit Services Division** • P.O. Box 942711, Sacramento, California 94229-2711

Goes to employer

Report of Separation and Advance Payroll Information

CalPERS

888 CalPERS (or 888-225-7377) • TTY for Speech and Hearing Impaired: (916) 795-3240

Employer: Please complete this form as soon as possible and return to CalPERS.

Section 1

Your cooperation in immediately providing an advance estimate of the requested information is critical for us to make accurate payment at the earliest possible date.

Employing Agency and Member Information

San Jose / Evergreen Valley College District
Name of Employing Agency

This member has applied for disability retirement.

Erlinda Velasquez
Name of Member (First Name, Middle Initial, Last Name) Social Security Number

07-04-2011
Requested Retirement Date (mm/dd/yyyy)

Section 2

Last day on pay status will be upon expiration of accrued sick leave or compensated time off.

Effective Separation or Termination Dates

Separation Date (mm/dd/yyy) | Termination Date (mm/dd/yyyy) | Last Day on Pay Status (mm/dd/yyyy)

Leave of Absence With Compensation

Beginning Date (mm/dd/yyyy) | Ending Date (mm/dd/yyyy) | Type of Compensation

Explain the difference between the date of separation and last day on pay status, if any. _____

Section 3

Unused Sick Leave at Time of Separation

Accumulated hours must be converted to **days** using the appropriate conversion factor applicable to each employee's individual classification or position. Calculate to three decimal places.

Balance of unused sick leave hours at time of separation: _____ (Hours) ÷ 8 = _____ (Days)

Section 4

Certification of Employer

The above information is based on payroll information currently available.

Signature of Payroll Officer | Title

Date (mm/dd/yyyy) | ( ) Phone Number

Mail to: **CalPERS Benefit Services Division** • P.O. Box 942711, Sacramento, California 94229-2711

Authorization to Disclose Protected Health Information

888 CalPERS (or 888-225-7377) • TTY for Speech and Hearing Impaired: (916) 795-3240 • Fax: (916) 795-1280

Section 1 — Member Information

Erlinda Velasquez

Name of Member (First Name, Middle Initial, Last Name) | Social Security Number

Daytime Phone | Evening Phone

Address

City | State | ZIP

I authorize the disclosure of my protected health information, including, but not limited to, medical histories, diagnoses, examination reports, chart notes, testing and test results, X-rays, operative reports, lab and medication records, prescriptions, and any other records relating to the prognosis, treatment or diagnosis of any physical, mental, psychological or psychiatric condition, to the California Public Employees' Retirement System (CalPERS) or its representative, for the sole purposes of determining my physical or mental condition, illness, or disability and my right, if any, to retirement or reinstatement under the Public Employees' Retirement Law (PERL) (Government Code sections 20000, et seq.). I understand that any information about me disclosed pursuant to this Authorization will be used by CalPERS for the administration of its duties under the PERL, the Social Security Act, and the Public Employees' Medical and Hospital Care Act. I understand that submission of the requested information is mandatory under Government Code section 20128 and that failure to supply the information requested may result in CalPERS being unable to make a determination regarding my status.

This Authorization applies to any and all health and/or medical related information about me in the possession of any health care provider, health plan, insurance company or fund, employer or plan administrator, government agency, organization or entity administering a benefit program, rehabilitation organization or program.

I understand that if my protected health information is disclosed to someone who is not required to comply with federal privacy protection regulations, that information may be re-disclosed and would no longer be protected.

I understand that I have a right to revoke this Authorization at any time. My revocation must be in writing by letter directed to the CalPERS Benefit Services Division at the address below. I am aware that my revocation is not effective to the extent that persons I have authorized to use and/or disclose my protected health information have acted in reliance upon this Authorization. Unless cancelled by me in writing, this Authorization shall be valid for four years from the date shown below. A photocopy of this Authorization shall be as valid as the original. I understand that I may request a copy of this Authorization at any time.

Section 2 — Authorization to Release Information

I also authorize the disclosure of any and all personnel and other employment-related records on file with any of my present or former employers which relate to my job duties, work performance, and other work-related issues including, but not limited to, attendance and sick leave records and records of administrative and judicial action arising out of, or related to, my past or present employment.

Signature of Member | 12-15-2010 Date (mm/dd/yyyy)

Mail to: **CalPERS Benefit Services Division** • P.O. Box 2796, Sacramento, California 95812-2796

Physician's Report on Disability

888 CalPERS (or 888-225-7377) • TTY for Speech and Hearing Impaired: (916) 795-3240 • Fax: (916) 795-1280

This form must be completed by a medical doctor. The following information is needed in connection with the patient's application for disability retirement benefits under the California Public Employees' Retirement Law.

Section 1

Please fill out completely and fully describe the nature and severity of impairment. Also, include copies of the patient's medical and referenced diagnostic test reports.

Member Information

Erlinda Velasquez
Name of Member/Patient (First Name, Middle Initial, Last Name)

Social Security Number

Position/Occupational Title

Birth Date (mm/dd/yyyy)

For Kaiser Patients, Medical Record Number

Section 2

Please provide history of patient's illness/injury.

Patient and Member are the same person.

Member History

MAY 7 2009
Date of First Visit (mm/dd/yyyy)

02/10/2011
Date of Last Examination (mm/dd/yyyy)

12/22/2010
Date Present Illness/Injury Occurred (mm/dd/yyyy)

12/22/2010
Date Member Unable to Perform Job Duties (mm/dd/yyyy)

Origin of Injury: ☑ Work Related ☑ Non-Work Related

STRESSORS BOTH WORK + NON-
WORK RELATED
Describe How Injury Occurred

Section 3

Please provide history of patient's illness/injury.

Examination Findings

DEPRESSION CAUSED BY DEATH OF BOSS
Chief Complaints JOB POLITICS, PERSONAL FINANCE + FAMILY ISSUES

INSOMNIA, INABILITY TO FOCUS
Subjective Symptoms OVERWHELMED, ANOREXIA, SUICIDAL THOUGHTS

Height | 178.2 Weight | 130/90 Blood Pressure

Section 4

Provide dates and findings of any X-rays, EKGs, laboratory or diagnostic testing performed. Use additional sheets if necessary.

If there is not enough space to enter all your diagnosis, attach a separate sheet. Be sure to use a label, or clearly write your Social Security number on each attachment.

Diagnosis

DEPRESSION
Diagnosis 1

CLINICAL
Objective Examination Findings 1

Diagnostic Test - Dates and Findings

Restrictions /Limitations, if so specify.

Diagnosis 2

Objective Examination Findings 2

Diagnostic Test - Dates and Findings

Restrictions /Limitations, if so specify.

Comments

Put your name and Social Security number at the top of every page.

Erlinda Velasquez
Your Name

Social Security Number

Section 5 Member Incapacity

Review the attached duty statement and physical requirements of the member's position prior to answering these questions.

To qualify for a disability retirement, the CalPERS member must be substantially incapacitated from the performance of the usual duties of his/her position with the current employer. This "substantial incapacity" must be due to a medical condition of permanent or extended and uncertain duration. Disability is not necessarily an inability to perform fully every function of a given position. Rather, the courts have concluded that the test is whether the member has a substantial inability to perform the usual and customary duties of the position. **Prophylactic restrictions are not a basis for a disability retirement.**

1. Is the member currently, substantially incapacitated from performance of the usual duties of the position for their current employer? ☑ Yes ☐ No
   If yes, you must describe specific work activities that the member is unable to perform due to incapacity.
   ALL TASKS
2. Will the incapacity be permanent? ☐ Yes ☑ No
   If not, probable duration ☐ < 6 months ☐ 6 months – 1 year ☑ 1 – 2 years ☐ Other
3. Was the job description/duty statement reviewed to make your medical opinion? ☑ Yes ☐ No
4. Was the Physical Requirements of Position/Occupational Title reviewed to make your medical opinion? ☐ Yes ☑ No
5. Was information reviewed that the member provided? ☐ Yes ☑ No
   If so, please attach the information provided by the member.

Section 6 Member Mental Status

Is the member mentally able to handle financial affairs and enter into legally binding contracts?
☑ Yes ☐ No _____ Date of Onset (mm/dd/yyyy)

Is the member competent to endorse checks with the realization of nature and consequence of the act?
☑ Yes ☐ No _____ Date of Onset (mm/dd/yyyy)

Section 7 Physician's Signature

Mail completed report directly to CalPERS. **Do not give to member.**

All questions on this form must be answered or application will be incomplete, which will delay processing.

CalPERS has my permission to release a photocopy of report to member, upon written request. ☑ Yes ☐ No

Print Physician Name: MARVIN P. MASADA, M.D.
Phone Number:
Fax Number: (408) 274-8021

Address: 1569 Lexann Ave., Suite 128
San Jose, CA 95121
(408) 274-1654

City
State
ZIP

Signature of Physician/Title: M Masada
Medical Specialty: FAMILY MEDICINE
Date (mm/dd/yyyy): 02/15/2011

Mail to: **CalPERS Benefit Services Division** • P.O. Box 2796, Sacramento, California 95812-2796

Sent to employer

my copy

Employer Information for Disability Retirement

888 CalPERS (or 888-225-7377) • TTY for Speech and Hearing Impaired: (916) 795-3240 • Fax: (916) 795-1280

Section 1 — Member Information

To Member: Complete this form, sign, date and forward to your employer.

To Employer: Use this form as a cover sheet for the employee's job description and other documents you submit to CalPERS.

Erlinda Velasquez
Name of Member (First Name, Middle Initial, Last Name)

Social Security Number

Payroll Technician
Position/Occupational Title

San Jose/Evergreen Valley District
Name of Employer/Agency

I have submitted an application for disability retirement with the California Public Employees' Retirement System (CalPERS). I am submitting this letter to you (my employer) on behalf of CalPERS. CalPERS is seeking information to substantiate my disability.

As soon as possible, please send CalPERS the duty statement/job description for the position I held. Please include a copy of all accident reports, medical reports, and personnel actions filed within the past five years. These documents must be identified with my name and Social Security number. If you have additional comments, please submit them.

CalPERS requires the physical requirements of my position/occupational title. I will be contacting you so we can complete the Physical Requirements of Position/Occupational Title form for my position. At that time, a copy of my duty statement/job description that you send to CalPERS must be provided to me. Both the duty statement/job description and the Physical Requirements of Position/Occupational Title form will be presented to my physician to assist in the evaluation of my disability retirement.

When the CalPERS determination of disability is completed, they will inform you. When you are notified of their determination, you will have the right to appeal the approval/denial of the application for disability retirement for the medical condition stated, in accordance with Section 555.3, Title II, California Code of Regulations by filing a written request with CalPERS within 30 days of the mailing of the determination letter. An appeal, if filed, should set forth the factual basis and legal authorities for such appeal.

Under the law, if a person (other than my employer) caused an injury that results in certain CalPERS benefits being paid, CalPERS has the right to recover from the responsible party up to one-half of the total retirement benefit costs payable. This right is known as a "right of subrogation" (Government Code Section 20250, et seq.).

Please advise CalPERS if you are aware of any claim (other than a workers' compensation claim) against any person or entity for the same injuries that also entitle me to a disability retirement from CalPERS.

Section 2 — Authorization to Release Information

Mail signed authorization to your employer, not CalPERS.

The purpose of this authorization is to assist CalPERS in determining my right to retirement or reinstatement under the Retirement Law, pursuant to Government Code Section 20128, and for no other purpose. This authorization will be valid for four years from the date shown below. A photocopy of this authorization shall be as valid as the original.

Signature of Member

12-15-2010
Date (mm/dd/yyyy)

Mail to: CalPERS Benefit Services Division • P.O. Box 2796, Sacramento, California 95812-2796

PERS01M0052DMC (9/05)

Physical Requirements of Position/Occupational Title

888 CalPERS (or 888-225-7377) • TTY for Speech and Hearing Impaired: (916) 795-3240 • Fax: (916) 795-1280

Section 1

This form must be completed by the member and their employer to supplement, if any, the physical requirements listed on the member's duty statement/job description.

Member Information

Erlinda Velasquez
Name of Member (First Name, Middle Initial, Last Name)

Social Security Number

Position/Occupational Title

San Jose/Evergreen Valley College (Dist
Name of Employer

4750 San Felipe Road [redacted] av
Worksite Street Address

San Jose,
City

CA
State

95135
ZIP

Section 2

Indicate with a check mark (✓) the frequency required for each activity listed at the right.

Physical Requirements Information

Activity	Never	Occasionally Up to 3 hours	Frequently 3–6 hours	Constantly Over 6 hours	Distance/ Height
Sitting	(N/A)				
Standing					
Running					
Walking					
Crawling					
Kneeling					
Climbing					
Squatting					
Bending (neck)					
Bending (waist)					
Twisting (neck)					
Twisting (waist)					
Reaching (above shoulder)					
Reaching (below shoulder)					
Pushing & Pulling					
Fine Manipulation					
Power Grasping					
Simple Grasping					
Repetitive use of hand(s)					
Keyboard Use					
Mouse Use					
Lifting/Carrying					
0 – 10 lbs.					
11 – 25 lbs.					
26 – 50 lbs.					
51 – 75 lbs.					
76 – 100 lbs.					
100 + lbs.					

Continued on page 2.

Request for Service Credit Cost Information — Service Prior to Membership, CETA & Fellowship

888 CalPERS (or 888-225-7377) • TTY For Speech & Hearing Impaired (916) 795-3240

Velasquez Erlinda
Name of Member (Last Name First Name Middle Initial) Social Security Number

Section 1 — About You

If we have provided cost information to you in the past for this service credit, check the Yes box and indicate the date your request was submitted. If you have submitted a retirement application, check the Yes box and indicate your planned retirement date.

Have you requested this cost information before? ☒ No ☐ Yes _____ Requested Date (mm/dd/yyyy)

Have you submitted a retirement application? ☒ No ☐ Yes _____ Requested Date (mm/dd/yyyy)

Were you compensated for this employment? ☐ No ☒ Yes

Erlinda Velasquez-Sandez San Jose/Evergreen Valley College DIST
Former Name (if applicable) Current Employer

Mailing Address

City State ZIP Code Daytime Phone

Section 2 — Prior Employment Information

List the name and address of the employer where the service was earned. If this was a certificated position, contact the State Teachers' Retirement System.

List the dates and hours of employment for which you are requesting credit. List each position separately and indicate if service was full time or part time. If the service was part time, show service as a fraction or list the hours (i.e., 20 hours per month or half time).

Evergreen Valley College District
Employer

3095 Yerba Buena Road
Address

San Jose CA 95135
City State ZIP Code

Was this service rendered under the Comprehensive Employment & Training Act from 1973 to 1982? ☒ No ☐ Yes

Was this service rendered under a fellowship program? ☐ No ☒ Yes Hourly Work Cal Works Work Fellowship Program
Name of Program

Was service rendered as a 10-month employee? ☒ No ☐ Yes Financial Aid Dept

03-19-1991 01-1994 3095 Yerba Buena Road
Employment From (mm/dd/yyyy) To (mm/dd/yyyy) Location

Hourly-Works/Financial Aid Clerk 25-35 hrs = 140 hrs per month (Summer minimum hrs-worked)
Position Title Hours Worked Per Month OR Time Base/Fraction of Full Time

10-1994 06-2-1996 Evergreen Valley College
Employment From (mm/dd/yyyy) To (mm/dd/yyyy) Location

Cal Works/Hourly Worker 25-35 hrs = 140 per month
Position Title Hours Worked Per Month OR Time Base/Fraction of Full Time

07-07-1996 08/1/1997 Evergreen Valley College
Employment From (mm/dd/yyyy) To (mm/dd/yyyy) Location

Cal-Works/Hourly Worker 25-35 hrs 140 per month
Position Title Hours Worked Per Month OR Time Base/Fraction of Full Time

Section 3 — Member Certification

I hereby certify that the above information is true and correct

Erlinda Velasquez 12-10-2010
Signature Date (mm/dd/yyyy)

- If the service was performed for the State of California or a California State University, stop. Sign this form on the line above and mail it to CalPERS.
- If the service was performed for the University of California, a CalPERS-covered public agency, or a school, forward this request form to the appropriate employer for completion of Page 2 before returning to CalPERS.

RECEIVED JAN 25 PM 3:44 SACRAMENTO-CALPERS

Put your name and Social Security number at the top of every page

Velasquez Erlinda
Name of Member (Last Name First Name Middle Initial) | Social Security Number

Section 4 — Statement & Signature of Personnel or Payroll Officer

If the service was performed for the State of California or California State University, employer certification is not required

Your signature certifies that the member-provided information is true, correct, and provides CalPERS with all the necessary information to apply any exclusions If no hours worked or time base is indicated, full-time service will be assumed If you do not agree with this assumption or with the information listed, continue to Section 5

Position Type ☐ Seasonal ☒ Limited Term ☐ On-Call ☐ Intermittent ☐ Permanent

For Teachers Assistants Only
Was this person employed pursuant to Section 44926 of the Education Code? ☐ No ☐ Yes

Do you feel this service is eligible for purchase? ☒ Yes ☐ No Reason: Employee Services

Marcela Disch | Director | 01-17-11
Employer Signature | Title | Date (mm/dd/yyyy)

MARCELA DISCH | 408-223-6737 | 408-274-7924
Printed Name | Daytime Phone | FAX

Section 5 — Employer Certification

To be completed by employer only if additional information is necessary Otherwise, simply certify in Section 4 above.

Complete Section 7 and return this request form to the member

Position Title | Employment From (mm/dd/yyyy) | To (mm/dd/yyyy)

Time Base ☐ Full Time ☐ Part Time ☒ Hourly ☐ Fraction of Full Time

Average Number of Days or Hours Per Month

Average Percentage or Fraction of Time Worked Per Month

Please see attachments.

Section 6 — Member Employment History

Complete Section 6 only if the employee was full time, worked more than 1,000 hours in a fiscal year (July 1 through June 30), or did not work a consistent time base and could not be listed above.

03-18-1991 | 06-30-1992 |
Employment From (mm/dd/yyyy) | Employment To (mm/dd/yyyy) | Position Title

Pay Rate (Hourly/Daily/Monthly) | Time Worked (Hours Per Day) | Time Worked (Earnings)

01-26-1998 | 08-20-1998 | Account Clerk
Employment From (mm/dd/yyyy) | Employment To (mm/dd/yyyy) | Position Title

$5.15/Hour up to 06/30/98
Pay Rate (Hourly/Daily/Monthly) | Time Worked (Hours Per Day) | Time Worked (Earnings)

07-01-1998 | 08-02-1998 | Account Clerk
Employment From (mm/dd/yyyy) | Employment To (mm/dd/yyyy) | Position Title

$5.75/Hour
Pay Rate (Hourly/Daily/Monthly) | Time Worked (Hours Per Day) | Time Worked (Earnings)

Employment From (mm/dd/yyyy) | Employment To (mm/dd/yyyy) | Position Title

Pay Rate (Hourly/Daily/Monthly) | Time Worked (Hours Per Day) | Time Worked (Earnings)

Section 7 — Statement & Signature of Personnel or Payroll Officer

If the service was performed for the State of California or California State University, employer certification is not required

I hereby certify that the above information is true and correct and provides CalPERS with all the necessary information to apply any exclusions

Marcela Disch | Employee Services Director | 01-17-2011
Signature | Title | Date (mm/dd/yyyy)

MARCELA DISCH | 408-223-6737 | 408-274-7924
Printed Name | Daytime Phone | FAX

Mail to: CalPERS Member Services Division • PO Box 4000, Sacramento, California 95812-4000