

**INFORMATION TO BE COMPLETED TO BE ELIGIBLE FOR  
SUBSTITUTE WORK IN THE CAFETERIAS:**

FORM	SIGNATURE REQUIRED	RECEIVED
APPLICATION FOR EMPLOYMENT (SUPPORT)	YES	
EMPLOYMENT QUESTIONNAIRE	YES	
FINGERPRINTS (OBTAINED AT SHERIFF'S OFFICE)	YES	
DISCLOSURE FORM	YES	
I-9 (U.S. DEPARTMENT OF JUSTICE FORM)	YES	
STATE & FEDERAL W-4 FORMS	YES	
PHYSICAL-PAGES 2 & 3 COMPLETED BY PHYSICIAN	YES	
DRESS CODE & HOURS OF WORK	YES	
T.B. PATCH TEST VERIFICATION (WITHIN 5 YEARS)		
DPT BOOSTER SHOT (WITHIN 10 YEARS)		
HIGH SCHOOL DIPLOMA		
SOCIAL SECURITY CARD		
DRIVER'S LICENSE		

PACKET RECEIVED & REVIEWED BY: \_\_\_\_\_

DATE: \_\_\_\_\_

ONCE COMPLETED PACKET IS RECEIVED AND REVIEWED, YOU WILL BE GIVEN AN EMPLOYEE HANDBOOK, FOR WHICH YOU MUST SIGN ACKNOWLEDGING RECEIPT.

**IF FURTHER ASSISTANCE IS NEEDED, PLEASE CONTACT  
MS. THERESA ATTALES AT 363-0049.**

**EVANGELINE PARISH SCHOOL BOARD**  
**1123 Te Mamou Road**  
**Ville Platte, LA 70586**  
**(337)363-6651**

**APPLICATION FOR EMPLOYMENT (Substitute)**  
**PERSONAL INFORMATION:**

Last Name	First	Middle	Date
Street Address			Home Phone (    )
City, State, Zip			Cell Phone (    )
Have you every applied for employed with us? Yes No If yes, Month and Year _____ Location _____			Business Phone (    )
Position Desired			E-mail address
Apart from absence for religious observations, are you available for full time work? (Number of days) _____ _____ Yes _____ No If not, what hours can you work? _____			Social Security Number
			Date of Birth (month/day/year)
Are you legally eligible for employment in the United States? _ Yes _ No			Ethnicity: Are You Hispanic/Latino Yes or No
Are you a retiree from the public school system? ___ Yes ___ No			Please select one or more of the following race: <input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Hispanic <input type="checkbox"/> Asian <input type="checkbox"/> Native American/Alaskan Native <input type="checkbox"/> Hawaiian(Pacific Islander)
Other special training or skills (language, machine operations, etc.)			
How did you learn of our organization?			When will you be available to begin work?

Have you ever been convicted of a felony for which you have not been pardoned?    _____ Yes _____ No
(Signature) _____ (Date) _____

**EDUCATION:**

TYPE	NAME AND LOCATION OF SCHOOL	COURSE OF STUDY	DEGREE OR DIPLOMA
High School		Major:	
		Minor:	
Other			

**NEPOTISM DISCLORUE:**

Are you an immediate family member of any member of the Evangeline Parish School Board or its Superintendent? _____ Yes _____ No (The term "immediate family" is defined by LA R.S. 42:1119(2)(a) to include children, spouses of children, brothers, sisters, parents, spouse, and the parents of the board members' or superintendent's spouse)
If your answer is "YES", explain your relationship: _____



**NEW EMPLOYEE VERIFICATION REPORTING FORM**

**(Act 97 of the 1997 Legislative Session)  
Effective October 1, 1997**

**TO: Child Support Enforcement Unit  
New Hire Division  
P. O. Box 2151  
Baton Rouge, LA. 70821**

**FROM: Employer: Evangeline Parish School Board  
1123 Te Mamou Road  
Ville Platte, LA 70586**

**Phone #: (337) 363-6651**

**EIN: Federal # 72-6000392  
State # LA0835348001**

-----  
**NEW EMPLOYEE:**

**NAME:** \_\_\_\_\_

**ADDRESS:** \_\_\_\_\_  
\_\_\_\_\_

**SOCIAL SECURITY #:** \_\_\_\_\_

**POSITION:** \_\_\_\_\_

**DATE OF EMPLOYMENT:** \_\_\_\_\_

**EMPLOYEE SIGNATURE:** \_\_\_\_\_

**DIRECTOR OF PERSONNEL:** \_\_\_\_\_

# Form W-4 (2010)

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

**Exemption from withholding.** If you are exempt, complete only lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2010 expires February 16, 2011. See Pub. 505, Tax Withholding and Estimated Tax.

**Note.** You cannot claim exemption from withholding if (a) your income exceeds \$950 and includes more than \$300 of unearned income (for example, interest and dividends) and (b) another person can claim you as a dependent on his or her tax return.

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

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

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

**Tax credits.** You can take projected tax credits into account in figuring your allowable number of withholding allowances. Credits for child or dependent care expenses and the child tax credit may be claimed using the **Personal Allowances Worksheet** below. See Pub. 919, How Do I Adjust My Tax Withholding, for information on converting your other credits into withholding allowances.

**Nonwage income.** If you have a large amount of nonwage income, such as interest or dividends, consider making estimated tax

payments using Form 1040-ES, Estimated Tax for Individuals. Otherwise, you may owe additional tax. If you have pension or annuity income, see Pub. 919 to find out if you should adjust your withholding on Form W-4 or W-4P.

**Two earners or multiple jobs.** If you have a working spouse or more than one job, figure the total number of allowances you are entitled to claim on all jobs using worksheets from only one Form W-4. Your withholding usually will be most accurate when all allowances are claimed on the Form W-4 for the highest paying job and zero allowances are claimed on the others. See Pub. 919 for details.

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

**Check your withholding.** After your Form W-4 takes effect, use Pub. 919 to see how the amount you are having withheld compares to your projected total tax for 2010. See Pub. 919, especially if your earnings exceed \$130,000 (Single) or \$180,000 (Married).

## Personal Allowances Worksheet (Keep for your records.)

<b>A</b>	Enter "1" for yourself if no one else can claim you as a dependent . . . . .	<b>A</b> _____
<b>B</b>	Enter "1" if: <ul style="list-style-type: none"> <li>• You are single and have only one job; or</li> <li>• You are married, have only one job, and your spouse does not work; or</li> <li>• Your wages from a second job or your spouse's wages (or the total of both) are \$1,500 or less.</li> </ul>	<b>B</b> _____
<b>C</b>	Enter "1" for your spouse. But, you may choose to enter "-0-" if you are married and have either a working spouse or more than one job. (Entering "-0-" may help you avoid having too little tax withheld.) . . . . .	<b>C</b> _____
<b>D</b>	Enter number of dependents (other than your spouse or yourself) you will claim on your tax return . . . . .	<b>D</b> _____
<b>E</b>	Enter "1" if you will file as head of household on your tax return (see conditions under <b>Head of household</b> above) . . . . .	<b>E</b> _____
<b>F</b>	Enter "1" if you have at least \$1,800 of child or dependent care expenses for which you plan to claim a credit . . . . .	<b>F</b> _____
<b>(Note. Do not include child support payments. See Pub. 503, Child and Dependent Care Expenses, for details.)</b>		
<b>G</b>	<b>Child Tax Credit</b> (including additional child tax credit). See Pub. 972, Child Tax Credit, for more information. <ul style="list-style-type: none"> <li>• If your total income will be less than \$61,000 (\$90,000 if married), enter "2" for each eligible child; then less "1" if you have three or more eligible children.</li> <li>• If your total income will be between \$61,000 and \$84,000 (\$90,000 and \$119,000 if married), enter "1" for each eligible child plus "1" additional if you have six or more eligible children.</li> </ul>	<b>G</b> _____
<b>H</b>	Add lines A through G and enter total here. <b>(Note. This may be different from the number of exemptions you claim on your tax return.)</b> ▶	<b>H</b> _____
	For accuracy, complete all worksheets that apply. <ul style="list-style-type: none"> <li>• If you plan to itemize or claim adjustments to income and want to reduce your withholding, see the <b>Deductions and Adjustments Worksheet</b> on page 2.</li> <li>• If you have more than one job or are married and you and your spouse both work and the combined earnings from all jobs exceed \$18,000 (\$32,000 if married), see the <b>Two-Earners/Multiple Jobs Worksheet</b> on page 2 to avoid having too little tax withheld.</li> <li>• If neither of the above situations applies, stop here and enter the number from line H on line 5 of Form W-4 below.</li> </ul>	

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

<b>Form W-4</b> Department of the Treasury Internal Revenue Service	<h2 style="margin: 0;">Employee's Withholding Allowance Certificate</h2> <p style="margin: 0;">▶ Whether you are entitled to claim a certain number of allowances or exemption from withholding is subject to review by the IRS. Your employer may be required to send a copy of this form to the IRS.</p>	OMB No. 1545-0074  <h1 style="font-size: 2em; margin: 0;">2010</h1>
1 Type or print your first name and middle initial. <span style="float: right;">Last name</span>		2 Your social security number
Home address (number and street or rural route)		3 <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Married, but withhold at higher Single rate. Note. If married, but legally separated, or spouse is a nonresident alien, check the "Single" box.
City or town, state, and ZIP code		4 If your last name differs from that shown on your social security card, check here. You must call 1-800-772-1213 for a replacement card. ▶ <input type="checkbox"/>
5 Total number of allowances you are claiming (from line H above or from the applicable worksheet on page 2)		5 _____
6 Additional amount, if any, you want withheld from each paycheck		6 \$ _____
7 I claim exemption from withholding for 2010, and I certify that I meet both of the following conditions for exemption. <ul style="list-style-type: none"> <li>• Last year I had a right to a refund of all federal income tax withheld because I had no tax liability and</li> <li>• This year I expect a refund of all federal income tax withheld because I expect to have no tax liability.</li> </ul> If you meet both conditions, write "Exempt" here . . . . . ▶		7 _____
Under penalties of perjury, I declare that I have examined this certificate and to the best of my knowledge and belief, it is true, correct, and complete.		
Employee's signature (Form is not valid unless you sign it.) ▶		Date ▶
8 Employer's name and address (Employer: Complete lines 8 and 10 only if sending to the IRS.)		9 Office code (optional) <span style="float: right;">10 Employer identification number (EIN)</span>



## Employee Withholding Exemption Certificate (L-4)

Louisiana Department of Revenue

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

**Instructions:** Employees who are subject to state withholding should complete the personal allowances worksheet indicating the number of withholding personal exemptions in Block A and the number of dependency credits in Block B.

- Employees must file a new withholding exemption certificate within 10 days if the number of their exemptions decreases, except if the change is the result of the death of a spouse or a dependent.
- Employees may file a new certificate any time the number of their exemptions increases.
- Line 8 should be used to increase or decrease the tax withheld for each pay period. Decreases should be indicated as a negative amount.

Penalties will be 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. If an employee fails to complete this withholding exemption certificate, the employer must withhold Louisiana income tax from the employee's wages without exemption.

**Note to Employer:** Keep this certificate with your records. If you believe that an employee has improperly claimed too many exemptions or dependency credits, please forward a copy of the employee's signed L-4 form with an explanation as to why you believe that the employee improperly completed this form and any other supporting documentation. The information should be sent to the Louisiana Department of Revenue, Criminal Investigations Division, PO Box 2389, Baton Rouge, LA 70821-2389.

**Block A**

- Enter "0" to claim neither yourself nor your spouse. You may enter "0" if you are married, and have a working spouse or more than one job to avoid having too little tax withheld.
- Enter "1" to claim yourself if you did not claim this exemption in connection with other employment, or if your spouse has not claimed your exemption. Enter "1" to claim one personal exemption if you will file as head of household.
- Enter "2" to claim yourself and your spouse.

A.

**Block B**

- Enter the number of dependents, not including yourself or your spouse, whom you will claim on your tax return. If no dependents 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. <input type="checkbox"/> No exemptions or dependents claimed <input type="checkbox"/> Single <input type="checkbox"/> Married	
4. Home address (number and street or rural route)			
5. City		State	ZIP
6. Total number of exemptions claimed in Block A			6.
7. Total number of dependents claimed in Block B			7.
8. Increase or decrease in the amount to be withheld each pay period. Decreases should be indicated as a negative amount.			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
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**APPLICANT PROCESSING – DISCLOSURE  
BUREAU OF CRIMINAL IDENTIFICATION AND  
INFORMATION**

P.O. BOX 66614 (MAIL SLIP A-6)  
BATON ROUGE, LA 70896

LSPAPP5/R10.03

EVANGELINE PARISH SCHOOL BOARD  
AGENCY

**NOTICE:**  
PLEASE PRINT OR TYPE INFORMATION,  
EXCLUDING ADMINISTRATORS OR  
AUTHORIZED PERSONS SIGNATURE.  
INCOMPLETE FORMS WILL NOT BE  
PROCESSED.

1123 TE MAMOU ROAD  
MAILING ADDRESS

VILLE PLATTE                      LA                      70586  
CITY                                      STATE                      ZIP CODE

\_\_\_\_\_  
NAME

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
DATE OF BIRTH

\_\_\_\_\_/\_\_\_\_\_  
RACE/SEX

\_\_\_\_\_  
SOCIAL SECURITY NUMBER

**ALL INFORMATION RELEASED MUST REMAIN STRICTLY CONFIDENTIAL AND ONLY  
THOSE AUTHORIZED BY LAW TO RECEIVE THIS INFORMATION MAY SUBMIT A  
REQUEST.**

**DO NOT WRITE BELOW THIS LINE: (For Bureau of Criminal Identification and Information Use Only)**

**NOTICE:** The response to your request for a criminal history check is based on a review of the State of Louisiana's criminal history records database as is available at the time of request. This does not preclude the possible existence of conviction information not available in our database.

**CRIMINAL HISTORY DETERMINATION:**

RAPSHEET ATTACHED

RESPONSE BELOW

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

**Form I-9, Employment  
Eligibility Verification**

Read instructions carefully before completing this form. The instructions must be available during completion of this form.

**ANTI-DISCRIMINATION NOTICE:** It is illegal to discriminate against work-authorized individuals. Employers CANNOT specify which document(s) they will accept from an employee. The refusal to hire an individual because the documents have a future expiration date may also constitute illegal discrimination.

**Section 1. Employee Information and Verification** (To be completed and signed by employee at the time employment begins.)

Print Name: Last	First	Middle Initial	Maiden Name
Address (Street Name and Number)		Apt. #	Date of Birth (month/day/year)
City	State	Zip Code	Social Security #

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

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

A citizen of the United States

A noncitizen national of the United States (see instructions)

A lawful permanent resident (Alien #) \_\_\_\_\_

An alien authorized to work (Alien # or Admission #) \_\_\_\_\_ until (expiration date, if applicable - month/day/year)

Employee's Signature \_\_\_\_\_ Date (month/day/year) \_\_\_\_\_

**Preparer and/or Translator Certification** (To be completed and signed if Section 1 is prepared by a person other than the employee.) I attest, under penalty of perjury, that I have assisted in the completion of this form and that to the best of my knowledge the information is true and correct.

Preparer's/Translator's Signature	Print Name
Address (Street Name and Number, City, State, Zip Code)	
Date (month/day/year)	

**Section 2. Employer Review and Verification** (To be completed and signed by employer. Examine one document from List A OR examine one document from List B and one from List C, as listed on the reverse of this form, and record the title, number, and expiration date, if any, of the document(s).)

List A	OR	List B	AND	List C
Document title: _____		_____		_____
Issuing authority: _____		_____		_____
Document #: _____		_____		_____
Expiration Date (if any): _____		_____		_____
Document #: _____		_____		_____
Expiration Date (if any): _____		_____		_____

**CERTIFICATION:** I attest, under penalty of perjury, that I have examined the document(s) presented by the above-named employee, that the above-listed document(s) appear to be genuine and to relate to the employee named, that the employee began employment on (month/day/year) \_\_\_\_\_ and that to the best of my knowledge the employee is authorized to work in the United States. (State employment agencies may omit the date the employee began employment.)

Signature of Employer or Authorized Representative	Print Name MICHAEL LOMBAS	Title PERSONNEL SUPERVISOR
Business or Organization Name and Address (Street Name and Number, City, State, Zip Code) EPSB-1123 TE MAMOU ROAD-VILLE PLATTE, LA. 70586		Date (month/day/year)

**Section 3. Updating and Reverification** (To be completed and signed by employer.)

A. New Name (if applicable)	B. Date of Rehire (month/day/year) (if applicable)
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C. If employee's previous grant of work authorization has expired, provide the information below for the document that establishes current employment authorization.

Document Title: \_\_\_\_\_ Document #: \_\_\_\_\_ Expiration Date (if any): \_\_\_\_\_

I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented document(s), the document(s) I have examined appear to be genuine and to relate to the individual.

Signature of Employer or Authorized Representative	Date (month/day/year)
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**NEW EMPLOYEE VERIFICATION REPORTING FORM**

**(Act 97 of the 1997 Legislative Session)  
Effective October 1, 1997**

**TO: Child Support Enforcement Unit  
New Hire Division  
P. O. Box 2151  
Baton Rouge, LA. 70821**

**FROM: Employer: Evangeline Parish School Board  
1123 Te Mamou Road  
Ville Platte, LA 70586**

**Phone #: (337) 363-6651**

**EIN: Federal # 72-6000392  
State # LA0835348001**

-----  
**NEW EMPLOYEE:**

**NAME:** \_\_\_\_\_

**ADDRESS:** \_\_\_\_\_  
\_\_\_\_\_

**SOCIAL SECURITY #:** \_\_\_\_\_

**POSITION:** \_\_\_\_\_

**DATE OF EMPLOYMENT:** \_\_\_\_\_

**EMPLOYEE SIGNATURE:** \_\_\_\_\_

**DIRECTOR OF PERSONNEL:** \_\_\_\_\_

# **POST-HIRE MEDICAL HISTORY QUESTIONNAIRE**

## **WARNING**

**“PURSUANT TO LSA-RS 23:1208 AND 1208.1 OF THE LOUISIANA WORKERS’ COMPENSATION ACT, I UNDERSTAND THAT THE FAILURE TO ANSWER TRUTHFULLY ANY OF THE QUESTIONS BELOW SHALL RESULT IN (1) A FINE OF NOT MORE THAN FIVE HUNDRED DOLLARS OR IMPRISONMENT FOR NOT MORE THAN TWELVE MONTHS, OR BOTH AND (2) A FORFEITURE OF COMPENSATION AND MEDICAL BENEFITS UNDER THE LOUISIANA WORKERS’ COMPENSATION ACT.”**

Please check in the appropriate space whether or not you currently have or have previously had any of the following conditions:

Epilepsy	<input type="checkbox"/> YES <input type="checkbox"/> NO	Headaches	<input type="checkbox"/> YES <input type="checkbox"/> NO
Diabetes	<input type="checkbox"/> YES <input type="checkbox"/> NO	Head Pain	<input type="checkbox"/> YES <input type="checkbox"/> NO
Heart Disease	<input type="checkbox"/> YES <input type="checkbox"/> NO	Hyperinsulism	<input type="checkbox"/> YES <input type="checkbox"/> NO
Arthritis	<input type="checkbox"/> YES <input type="checkbox"/> NO	Muscular Dystrophy	<input type="checkbox"/> YES <input type="checkbox"/> NO
Amputated Foot, Leg, Arm or Hand or Loss of Use Thereof	<input type="checkbox"/> YES <input type="checkbox"/> NO	Arteriosclerosis	<input type="checkbox"/> YES <input type="checkbox"/> NO
Loss of Sight, Partial or Total	<input type="checkbox"/> YES <input type="checkbox"/> NO	Thrombophlebitis	<input type="checkbox"/> YES <input type="checkbox"/> NO
Double Vision or Blurred Sight	<input type="checkbox"/> YES <input type="checkbox"/> NO	Varicose Veins	<input type="checkbox"/> YES <input type="checkbox"/> NO
Poliomyelitis	<input type="checkbox"/> YES <input type="checkbox"/> NO	Heavy Metal Poisoning	<input type="checkbox"/> YES <input type="checkbox"/> NO
Cerebral Palsy	<input type="checkbox"/> YES <input type="checkbox"/> NO	Brain Damage	<input type="checkbox"/> YES <input type="checkbox"/> NO
Multiple Sclerosis	<input type="checkbox"/> YES <input type="checkbox"/> NO	Discectomy	<input type="checkbox"/> YES <input type="checkbox"/> NO
Parkinson’s Disease	<input type="checkbox"/> YES <input type="checkbox"/> NO	Spinal Fusion	<input type="checkbox"/> YES <input type="checkbox"/> NO
Stroke	<input type="checkbox"/> YES <input type="checkbox"/> NO	Surgical Removal of Lumbar or Cervical Disc	<input type="checkbox"/> YES <input type="checkbox"/> NO
Tuberculosis	<input type="checkbox"/> YES <input type="checkbox"/> NO	Cervical Fusion	<input type="checkbox"/> YES <input type="checkbox"/> NO
Silicosis	<input type="checkbox"/> YES <input type="checkbox"/> NO	Knee Pain	<input type="checkbox"/> YES <input type="checkbox"/> NO
Asbestosis	<input type="checkbox"/> YES <input type="checkbox"/> NO	Knee Soreness	<input type="checkbox"/> YES <input type="checkbox"/> NO
Mental Disability	<input type="checkbox"/> YES <input type="checkbox"/> NO	Shooting Pains	<input type="checkbox"/> YES <input type="checkbox"/> NO
Hemophilia	<input type="checkbox"/> YES <input type="checkbox"/> NO	Numbness	<input type="checkbox"/> YES <input type="checkbox"/> NO

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

EMPLOYER SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

## WARNING

**“PURSUANT TO LSA-RS 23:1208 AND 1208.1 OF THE LOUISIANA WORKERS’ COMPENSATION ACT, I UNDERSTAND THAT THE FAILURE TO ANSWER TRUTHFULLY ANY OF THE QUESTIONS BELOW SHALL RESULT IN (1) A FINE OF NOT MORE THAN FIVE HUNDRED DOLLARS OR IMPRISONMENT FOR NOT MORE THAN TWELVE MONTHS, OR BOTH AND (2) A FORFEITURE OF COMPENSATION AND MEDICAL BENEFITS UNDER THE LOUISIANA WORKERS’ COMPENSATION ACT.”**

Osteomyelitis	<input type="checkbox"/> YES <input type="checkbox"/> NO	Tingling	<input type="checkbox"/> YES <input type="checkbox"/> NO
Head Injury	<input type="checkbox"/> YES <input type="checkbox"/> NO	Dizziness	<input type="checkbox"/> YES <input type="checkbox"/> NO
Nervous Breakdown, Anxiety or Depression	<input type="checkbox"/> YES <input type="checkbox"/> NO	High Blood Pressure	<input type="checkbox"/> YES <input type="checkbox"/> NO
Ionizing Radiation Injury	<input type="checkbox"/> YES <input type="checkbox"/> NO	Rotator Cuff Injury	<input type="checkbox"/> YES <input type="checkbox"/> NO
Compressed Air Sequelae	<input type="checkbox"/> YES <input type="checkbox"/> NO	Pain and/or Stiffness in Toe(s)	<input type="checkbox"/> YES <input type="checkbox"/> NO
Bronchitis	<input type="checkbox"/> YES <input type="checkbox"/> NO	Sore Neck	<input type="checkbox"/> YES <input type="checkbox"/> NO
Emphysema	<input type="checkbox"/> YES <input type="checkbox"/> NO	Neck Pain	<input type="checkbox"/> YES <input type="checkbox"/> NO
Asthma	<input type="checkbox"/> YES <input type="checkbox"/> NO	Neck Ache	<input type="checkbox"/> YES <input type="checkbox"/> NO
Ruptured Disc(s)	<input type="checkbox"/> YES <input type="checkbox"/> NO	Sore Back	<input type="checkbox"/> YES <input type="checkbox"/> NO
Bulging Disc(s)	<input type="checkbox"/> YES <input type="checkbox"/> NO	Back Pain	<input type="checkbox"/> YES <input type="checkbox"/> NO
Tingling Sensation in Arms, Legs, Fingers or Toes	<input type="checkbox"/> YES <input type="checkbox"/> NO	Back Ache	<input type="checkbox"/> YES <input type="checkbox"/> NO
Leg Pain	<input type="checkbox"/> YES <input type="checkbox"/> NO	Difficulty Moving Neck	<input type="checkbox"/> YES <input type="checkbox"/> NO
Leg Soreness	<input type="checkbox"/> YES <input type="checkbox"/> NO	Difficulty Moving Back	<input type="checkbox"/> YES <input type="checkbox"/> NO
Fractured or Broken Bones	<input type="checkbox"/> YES <input type="checkbox"/> NO	Knee Injury	<input type="checkbox"/> YES <input type="checkbox"/> NO
Difficulty Lifting	<input type="checkbox"/> YES <input type="checkbox"/> NO	Loss of Consciousness	<input type="checkbox"/> YES <input type="checkbox"/> NO
Difficulty Stooping	<input type="checkbox"/> YES <input type="checkbox"/> NO	Difficulty Moving Lower Extremities	<input type="checkbox"/> YES <input type="checkbox"/> NO
Difficulty Bending	<input type="checkbox"/> YES <input type="checkbox"/> NO	Difficulty Moving Knees	<input type="checkbox"/> YES <input type="checkbox"/> NO
Shooting Pains Down From Back Through Lower Extremities	<input type="checkbox"/> YES <input type="checkbox"/> NO	Knee Stiffness	<input type="checkbox"/> YES <input type="checkbox"/> NO
Shooting Pains Down From Neck or Upper Back Through Arms	<input type="checkbox"/> YES <input type="checkbox"/> NO	Back Stiffness	<input type="checkbox"/> YES <input type="checkbox"/> NO

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

EMPLOYER SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

**WARNING**

**“PURSUANT TO LSA-RS 23:1208 AND 1208.1 OF THE LOUISIANA WORKERS’ COMPENSATION ACT, I UNDERSTAND THAT THE FAILURE TO ANSWER TRUTHFULLY ANY OF THE QUESTIONS BELOW SHALL RESULT IN (1) A FINE OF NOT MORE THAN FIVE HUNDRED DOLLARS OR IMPRISONMENT FOR NOT MORE THAN TWELVE MONTHS, OR BOTH AND (2) A FORFEITURE OF COMPENSATION AND MEDICAL BENEFITS UNDER THE LOUISIANA WORKERS’ COMPENSATION ACT.”**

Hodgkin’s Disease	<input type="checkbox"/> YES <input type="checkbox"/> NO	Neck Stiffness	<input type="checkbox"/> YES <input type="checkbox"/> NO
Mental Retardation	<input type="checkbox"/> YES <input type="checkbox"/> NO	Neck Injury or Neck Symptoms	<input type="checkbox"/> YES <input type="checkbox"/> NO
Carpal Tunnel Syndrome	<input type="checkbox"/> YES <input type="checkbox"/> NO	Back Injury or Back Symptoms	<input type="checkbox"/> YES <input type="checkbox"/> NO
Hypertension	<input type="checkbox"/> YES <input type="checkbox"/> NO	Pain and/or Stiffness in Finger(s)	<input type="checkbox"/> YES <input type="checkbox"/> NO
Pain and/or Stiffness in Hand(s)	<input type="checkbox"/> YES <input type="checkbox"/> NO	Shoulder Pain	<input type="checkbox"/> YES <input type="checkbox"/> NO
Foot Ailment/Pain	<input type="checkbox"/> YES <input type="checkbox"/> NO	Pain and/or Stiffness in Wrist(s)	<input type="checkbox"/> YES <input type="checkbox"/> NO
Arthroscopy	<input type="checkbox"/> YES <input type="checkbox"/> NO	Hearing Loss	<input type="checkbox"/> YES <input type="checkbox"/> NO

If you answered **YES** to any of the conditions, **please explain below** the nature of your injury, condition, or the type of treatment received, the name, address and phone number of the doctor providing the treatment and any impairment or disability that may have been assigned as a result of the injury.

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

EMPLOYER SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

**WARNING**

**"PURSUANT TO LSA-RS 23:1208 AND 1208.1 OF THE LOUISIANA WORKERS' COMPENSATION ACT, I UNDERSTAND THAT THE FAILURE TO ANSWER TRUTHFULLY ANY OF THE QUESTIONS BELOW SHALL RESULT IN (1) A FINE OF NOT MORE THAN FIVE HUNDRED DOLLARS OR IMPRISONMENT FOR NOT MORE THAN TWELVE MONTHS, OR BOTH AND (2) A FORFEITURE OF COMPENSATION AND MEDICAL BENEFITS UNDER THE LOUISIANA WORKERS' COMPENSATION ACT."**

Has any doctor ever restricted your activities?  YES  NO

If you answered YES, please list the medical condition, type of restrictions placed, whether these restrictions were temporary or permanent, and whether you are presently under these restrictions.

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Have you ever been assessed any percentage of permanent disability to any part of your body for any reason whatsoever?  YES  NO

If you answered YES, please explain:

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Are you presently under any medical treatment by a doctor, chiropractor, psychiatrist, psychologist or other health care provider?  YES  NO

If you answered YES, please list the medical condition(s) being treated, the name of the doctor(s), field of specialty, address and telephone number.

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Are you presently taking any medication?  YES  NO

If you answered YES, please list the name of the medication, the medical condition being treated, and the name, address and telephone number of the doctor who prescribed the medication.

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

EMPLOYER SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

Revised 1/06

**WARNING**

**"PURSUANT TO LSA-RS 23:1208 AND 1208.1 OF THE LOUISIANA WORKERS' COMPENSATION ACT, I UNDERSTAND THAT THE FAILURE TO ANSWER TRUTHFULLY ANY OF THE QUESTIONS BELOW SHALL RESULT IN (1) A FINE OF NOT MORE THAN FIVE HUNDRED DOLLARS OR IMPRISONMENT FOR NOT MORE THAN TWELVE MONTHS, OR BOTH AND (2) A FORFEITURE OF COMPENSATION AND MEDICAL BENEFITS UNDER THE LOUISIANA WORKERS' COMPENSATION ACT."**

Have you ever had surgery to any part of your body?  YES  NO

If you answered YES, please list the part(s) of the body operated on, the type of operation performed, the date of the operation, the name of the hospital, if any, where the operation was performed, and the name, address and phone number of the doctor performing the surgery.

Have you ever received treatment for your back, neck, knees or lower extremities from a doctor, chiropractor, therapist or other health care provider?  YES  NO

If you answered YES, please list the name, address and phone number of all doctors, chiropractors, therapists or other health care providers who provided such treatment, the dates of the treatment and the diagnosis provided.

Have you ever had an injury which required you to miss time from work?  YES  NO

If you answered YES, please list the type of injury, the amount of time missed from work, whether the condition was fully resolved or if it left you with any impairment, and whether you returned to work.

Are you aware of any condition or injury that might impair or limit your ability to work for this company?  YES  NO

If you answered YES, please describe the condition or injury.

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

EMPLOYER SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

**WARNING**

**"PURSUANT TO LSA-RS 23:1208 AND 1208.1 OF THE LOUISIANA WORKERS' COMPENSATION ACT, I UNDERSTAND THAT THE FAILURE TO ANSWER TRUTHFULLY ANY OF THE QUESTIONS BELOW SHALL RESULT IN (1) A FINE OF NOT MORE THAN FIVE HUNDRED DOLLARS OR IMPRISONMENT FOR NOT MORE THAN TWELVE MONTHS, OR BOTH AND (2) A FORFEITURE OF COMPENSATION AND MEDICAL BENEFITS UNDER THE LOUISIANA WORKERS' COMPENSATION ACT."**

**I HAVE READ AND FULLY UNDERSTAND THE ABOVE.**

**EMPLOYEE SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**1208.1 Employer's inquiry into employee's previous injury claims:  
Forfeiture of Benefits**

Nothing in this Title shall prohibit an employer from inquiring about previous injuries, disabilities, or other medical conditions and the employee shall answer truthfully; failure to answer truthfully shall result in the employee's forfeiture of benefits under this Chapter, provided said failure to answer directly relates to the medical condition for which a claim for benefits is made or affects the employer's ability to receive reimbursement from the second injury fund. This section shall not be enforceable unless the written form on which the inquiries about previous medical conditions are made contains a notice advising the employee that his failure to answer truthfully may result in his forfeiture or workers' compensation benefits under R.S. 23:1208:1. Such notice shall be prominently displayed in bold-faced block lettering of no less than ten point type.

**I HAVE REVIEWED THE INFORMATION PROVIDED BY THE ABOVE-SIGNED EMPLOYEE ON THIS POST-HIRE MEDICAL HISTORY QUESTIONNAIRE AND AFFIRM THAT I HAVE KNOWLEDGE OF ANY MEDICAL CONDITIONS DISCLOSED HEREIN BY THE EMPLOYEE.**

**EMPLOYER SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

\_\_\_\_\_  
NAME OF EMPLOYEE

\_\_\_\_\_  
NAME OF SCHOOL

ADDRESS \_\_\_\_\_

TELEPHONE NUMBER \_\_\_\_\_

SOCIAL SECURITY NUMBER \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_ PRESENT AGE \_\_\_\_\_

RACE \_\_\_\_\_

MARITAL STATUS \_\_\_\_\_ NAME OF SPOUSE \_\_\_\_\_

FAMILY DOCTOR \_\_\_\_\_

**EVANGELINE PARISH CAFETERIA EMPLOYEE  
PHYSICAL EXAMINATION & HEALTH RECORD**

**NAME OF EMPLOYEE:** \_\_\_\_\_

**ADDRESS:** \_\_\_\_\_

**AGE:** \_\_\_\_\_ **DATE OF BIRTH:** \_\_\_\_\_

**HEIGHT:** \_\_\_\_\_ **WEIGHT:** \_\_\_\_\_

**I PHYSICAL FITNESS**

1. **Heart:** \_\_\_\_\_ **Lungs:** \_\_\_\_\_
2. **Blood Pressure:** \_\_\_\_\_  
**High:** \_\_\_\_\_ **Low:** \_\_\_\_\_ **Normal:** \_\_\_\_\_

**Is patient being treated for blood pressure at this time? Yes** \_\_\_\_\_ **No** \_\_\_\_\_

**II STATEMENT OF MEDICAL EXAMINER:**

**To the best of your knowledge, has patient ever had?**

1. **Dizziness, fainting spells, epilepsy, nervous breakdown, severe headaches, or any disorder of the brain or nervous system?**  
**Yes** \_\_\_\_\_ **When** \_\_\_\_\_ **No** \_\_\_\_\_
2. **Emotional or mental disorder?**  
**Yes** \_\_\_\_\_ **When** \_\_\_\_\_ **No** \_\_\_\_\_
3. **Has patient ever used barbiturates, sedatives, or tranquilizers habitually, or ever used morphine or any other narcotic drug?**  
**Yes** \_\_\_\_\_ **When** \_\_\_\_\_ **No** \_\_\_\_\_
4. **Asthma, emphysema, hay fever, chronic cough, spitting of blood, tuberculosis or any disease or disorder of the lungs or respiratory system?**  
**Yes** \_\_\_\_\_ **When** \_\_\_\_\_ **No** \_\_\_\_\_
5. **Has patient had tuberculosis patch test administered this year? (Attach copy of results.)**  
**Yes** \_\_\_\_\_ **When** \_\_\_\_\_ **No** \_\_\_\_\_

6. **High blood pressure, chest pain, shortness of breath, heart murmur or any disease or disorder of the heart or circulatory system?**  
Yes \_\_\_\_\_ When \_\_\_\_\_ No \_\_\_\_\_
7. **Arthritis, rheumatism, or any disease or disorder of the back, spine, bones, joints, or muscles?**  
Yes \_\_\_\_\_ When \_\_\_\_\_ No \_\_\_\_\_
8. **Diabetes or sugar, albumin or blood in his/her urine?**  
Yes \_\_\_\_\_ When \_\_\_\_\_ No \_\_\_\_\_
9. **Any disease or disorder of the eyes, nose or throat?**  
Yes \_\_\_\_\_ When \_\_\_\_\_ No \_\_\_\_\_
10. **Does patient have any abnormality, deformity, disease or disorder, or has patient been receiving treatment or taking medication of any kind?**  
Yes \_\_\_\_\_ When \_\_\_\_\_ No \_\_\_\_\_
11. **Has patient in the past 5 years, used alcoholic beverages to excess or intoxication?**  
Yes \_\_\_\_\_ When \_\_\_\_\_ No \_\_\_\_\_
12. **Has patient received tetanus injection or booster during the past 10 years?**  
Yes \_\_\_\_\_ When \_\_\_\_\_ No \_\_\_\_\_
13. **Does patient have any sores or lesions on hands or arms which could affect his/her ability to handle food?**  
Yes \_\_\_\_\_ When \_\_\_\_\_ No \_\_\_\_\_
14. **Is the individual under any type of medication at his time?**  
Yes \_\_\_\_\_ No \_\_\_\_\_  
**If yes, state condition and type of medication prescribed.**

\_\_\_\_\_  
\_\_\_\_\_

**I have examined \_\_\_\_\_ and find him/her to be free, in accordance with the items listed above, from any ailment, disease or defect that might affect his/her ability to work in a school food service establishment.**

\_\_\_\_\_  
**Signature of Examining Physician**

\_\_\_\_\_  
**Date**

**EMPLOYEE CERTIFICATION**

**I CERTIFY THAT THE ABOVE AND FOREGOING INFORMATION IS TRUE AND CORRECT.**

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**Signature of Employee**

**Date**

**If tetanus injection or booster has not been received in the past ten (10) years, this may be taken at the Evangeline Parish Health Unit. It would be best if you called for an appointment, 337-363-1135 (Ville Platte) or 337-468-5903 (Mamou). Documentation must be produced to the effect that tetanus injection or booster has been received.**

**EVANGELINE PARISH CHILD NUTRITION PROGRAM  
DRESS CODE & HOURS OF WORK**

**PERSONAL APPEARANCE:** Uniforms must be of the same color and of a fabric that contains at least 80% cotton - no cotton knits or jersey, no clinging fabrics. Effective hair restraints, hose, and low-heeled, enclosed shoes with nonskid soles that provide adequate protection are standard for school food service employees and volunteer workers. Aprons (provided by the cafeteria) should be worn over uniforms during food preparation and clean-up periods. All employees and volunteer workers should be clean and neat at all times. Jewelry is not recommended; however, plain wedding bands and watches are allowed, if they do not come into contact with food. A laboratory coat may be worn over a uniform. A washable sweater (not woolen) may be worn when necessary.

**HOURS OF WORK:** All full time school food service employees are required to work a minimum of 7 hours per day, with 30 minutes for lunch time, (a total of 7.5 hours). Policies regarding the time of reporting and leaving, permits to leave, number of days, hours per day to work and salaries are all the responsibility of the Evangeline Parish School Board.

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**Signature of Employee**

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**Date**

## **ELECTRONIC COMMUNICATIONS BETWEEN EMPLOYEES AND STUDENTS**

The Evangeline Parish School Board shall require that all communications between employees and students be appropriate and in accordance with state law. All electronic or any other communications by employees to students at any time shall be expected to be professional, acceptable in content to any reasonable person, and limited to information that is school-related or is acceptable to both student and parent.

All electronic communication, including electronic mail, by an employee at a school to a student enrolled at that school relative to the educational services provided to the student shall use a means provided by or otherwise made available by the school system for this purpose and the School Board shall prohibit the use of all such system means to electronically communicate with a student for a purpose not related to such educational services, except communication with an immediate family member if such communication is specifically authorized by the School Board.

Any electronic communication made by an employee at a school to a student enrolled at that school or that is received by an employee at a school from a student enrolled at that school using a means other than one provided by or made available by the school system shall be reported by the employee in a manner deemed appropriate by the School Board. Records of any such reported communication shall be maintained by the School Board for a period of at least one (1) year.

### **DEFINITIONS**

1. *Electronic Communication* includes any direct communication facilitated by voice or text-based telecommunication devices, or both, computers, as well as those devices that facilitate indirect communication using an intermediate method, including but not limited to Internet-based social networks. It shall also include transfer of signs, signals, writing, images, sounds, data, or intelligence of any nature in whole or in part by wire, radio, electromagnetic, photoelectric, or photo-optical system and pertains to both personal and School Board issued devices.
2. *Electronic mail* — the transmission of text-based information or communication by use of the Internet, computers, a facsimile machine, a pager, a cellular telephone, a video recorder, or any other electronic device or means sent to a person identified by a unique address or address number and received by that person.
3. *Computers* — pertains to any and all computers.
4. *Social networks* — locations on the Internet where users may interact with other users -- examples are Facebook, MySpace, YouTube, and other social networks sites available on the internet.

- 2. The supervisor shall meet with the employee to document his/her response to the allegation. The employee shall be required to cooperate fully with the investigation.
- 3. All information of the investigation shall be provided to the Superintendent and the Personnel Director by the supervisor.

Violations of this policy or any implementing regulations or procedures may result in discipline of the employee up to and including termination of employment

New policy: October, 2009

Ref: La. Rev. Stat. Ann. §§14:40.3, 17:81, 17:239; Board minutes, 10-21-09.

\*\*\*\*\*

After you have read this policy, please sign below and return to the Central Office.

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I, \_\_\_\_\_, have received a copy of the "Electronic  
Please Print Name  
Communications between Employees and Students" policy, File GAMIA, and will  
comply with its mandates.

\_\_\_\_\_  
Substitute's Signature

\_\_\_\_\_  
Date