PHONE # 409-584-2655

WEST SABINE ISD
P.O.BOX 869
PINELAND, TEXAS 75968

FAX # 409-584-2139

EMPLOYMENT APPLICATION FOR SUBSTITUTE TEACHER

An Equal Opportunity Employer*

Date of application _____

Personal Data

Name _____
Last *First* *Middle initial*

Current address _____
Street/Box *City* *State* *ZIP Code*

Other address where you may be reached _____

Home phone _____ Cell phone _____ Other phone _____

Other name that may appear on records _____

(Used for certification, reference, and criminal history record checks)

Assignment Preference

Please list the days you are available to substitute and your assignment preferences.

Day(s) of week ❑ Every day
❑ Monday ❑ Tuesday ❑ Wednesday ❑ Thursday ❑ Friday

Assignment ❑ Any assignment
❑ Elementary ❑ Intermediate ❑ Secondary ❑ Special Education

Preferred campuses _____

_____

Are you receiving Texas Teacher Retirement (TRS) benefits? ❑ Yes ❑ No
(The amount of time that an individual receiving TRS benefits may be employed without affecting benefits is governed by TRS rules and laws.)

Position Data

Credentials included with application:

❑ Résumé
❑ All teaching and professional certificates or licenses
❑ All transcripts showing degrees

Have you been employed by West Sabine ISD in the past? ❑ Yes ❑ No

If you answered yes, provide dates of employment _____

Education/Training

List the highest level of education attained: _____

Licenses and certificates granted _____

Name and location of schools attended	Course of study and major/minor	Diploma, degree, certificate, or license granted	Year graduated *(College only)*

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Certification

Certificates or Licenses Currently Held:

- ❑ None
- ❑ Valid Texas
- ❑ Valid Other State_____
- ❑ Texas One-Year (out-of-state/country): Expiration date: _____
- ❑ Other: _____

Category/Level(s) of Certification: _____ _____

Areas of Specialization/Supplemental Certificates/Endorsements (as listed on certification):

_____ _____

_____ _____

_____ _____

Teaching Experience

List teaching experience beginning with most recent years.

Name and location of school		Name and location of school	
Type of assignment		Type of assignment	
Dates taught		Dates taught	
Principal's name and phone		Principal's name and phone	
Reason for leaving		Reason for leaving	
Name and location of school		Name and location of school	
Type of assignment		Type of assignment	
Dates taught		Dates taught	
Principal's name and phone		Principal's name and phone	
Reason for leaving		Reason for leaving	

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Other Work Experience

Please provide a list of all other jobs or administrative positions you have held in the past 10 years. Attach additional sheets if necessary. Attach résumé if available.

Employer name and location		Employer name and location	
Position/title held		Position/title held	
Dates employed		Dates employed	
Supervisor's name and phone		Supervisor's name and phone	
Reason for leaving		Reason for leaving	
Employer name and location		Employer name and location	
Position/title held		Position/title held	
Dates employed		Dates employed	
Supervisor's name and phone		Supervisor's name and phone	
Reason for leaving		Reason for leaving	

References

Please list references the district can contact regarding your work history.

Full name of reference	School district/ firm name	Mailing address	Position/title	Area code/ phone number

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EMPLOYMENT APPLICATION FOR SUBSTITUTE TEACHER

General Information

Have you ever been convicted of, pled guilty or no contest (nolo contendre) to, or received probation, suspension, or deferred adjudication for a felony or any offense involving moral turpitude (including, but not limited to, theft, rape, murder, swindling, and indecency with a minor)? ❑ Yes ❑ No

If yes, please state where, when, and the nature of the offense_____

_____

_____

_____

(A felony conviction is not an automatic bar to employment. The district will consider the nature, date, and relationship between the offense and the position for which you are applying.)

Verification

I hereby affirm that all information provided in this application is true and accurate to the best of my knowledge and understand that any deliberate falsifications, misrepresentations, or omissions of fact may be grounds for rejection of my application or dismissal from sub sequent employment.

I authorize the references listed on the previous page to give you any and all information concerning my previous employment and any pertinent information they may have, per sonal or otherwise, and release all such parties from liability for any damage that may result from furnishing the same to you.

I understand that the district is required by Texas Education Code to review criminal history record information of substitute teachers.

_____ _____

Signature Date

This application becomes the property of the district. The district reserves the right to accept or reject it.

**Applicants for all positions are considered without regard to race, color, national origin, religion, sex, marital status, veteran or military status, disability, or any other legally protected status*

The district Title IX Coordinator is: Mike Pate
101 Timberland
P.O. Box 869
Pineland, Texas 75968
409-584-2655

CRIMINAL HISTORY INFORMATION REQUEST

Confidential*

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

Please print.

Name _____
Last *First* *Middle*

Social Security Number _____ Date of birth _____

Driver's License _____
State and Number

Mailing Address _____
Street *City* *State* *Zip*

Sex: ❑ Male ❑ Female Ethnicity: ❑ Black ❑ White/Other

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

I understand before I can work for West Sabine ISD I must be fingerprinted. I also understand I am responsible for any expenses incurred in this process. Please check one of the following:

_____ Begin the fingerprint process.
_____ Do not begin the fingerprint process at this time. I will notify you later.

_____
Signature

_____
Date

_____

DPS Computerized Criminal History (CCH) Verification

(AGENCY COPY)

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

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

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

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

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

_____
Signature of Applicant or Employee

_____
Date

WEST SABINE ISD
Agency Name (Please print)

CARLA POWELL
Agency Representative Name (Please print)

Carla Powell
Signature of Agency Representative

07/12/12
Date

Please:
Check and Initial each Applicable Space

CCH Report Printed:

YES ☐ NO ☐ _____ initial

Purpose of CCH: _____

Hire ☐ Not Hired ☐ _____ initial

Date Printed: _____ _____ initial

Destroyed Date: _____ _____ initial

Retain in your files

Rev. 02/2011

WEST SABINE INDEPENDENT SCHOOL DISTRICT

PO BOX 869
PINELAND, TX 75968
PHONE: 409-584-2655 FAX: 409-584-2139

West Sabine ISD provides health coverage to employees through TRS-ActiveCare. A district substitute is eligible to enroll in TRS-ActiveCare if the district reasonably expects the substitute to work at least 10 hours per week. Hours worked for other school districts are not considered in determining whether a substitute is eligible for benefits through West Sabine ISD.

Although the district reasonably expects substitutes to work at least 10 hours per week, the district does not guarantee that you will receive 10 hours every week. The district's need for substitutes varies from week to week. In some weeks, you may not receive any assignments. Similarly, the district understands that some weeks you may not be able to accept assignments due to illness or other personal reasons.

If you are a new substitute, you must enroll in or decline medical coverage within 31 days from date of hire. If you are a returning substitute, you must enroll in or decline medical coverage during the annual open enrollment. If you decline coverage, you cannot enroll again until the next plan year unless you experience a special enrollment event.

If you elect to enroll, you will be responsible for the full premium. You must submit payment for one calendar month with your enrollment form. The premiums for subsequent months will be deducted from your pay for the preceding month. If your pay is not sufficient to cover the full premium, you must submit the difference to the district by the 25th day of the preceding month. If the 25th day falls on a weekend or a day the district is closed, the payment must be made the preceding business day. If you fail to timely pay the monthly premiums, the district will proceed with the coverage cancellation process. Your coverage may also be cancelled if you lose eligibility for TRS-ActiveCare.

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

- you repeatedly turn down assignments, are repeatedly unavailable for calls, or frequently cancel assigned positions
- you do not accept at least 10 assignments per year
- you do not timely return a letter of reasonable assurance

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

If you have any questions or need additional information regarding this matter, please call Sherry Boyett or Natasha McClelland at 584-2655. Thank you.

Sincerely,

Mike Pate
Superintendent

TRS ACTIVECARE

Enrollment Application and Change Form

WellSystems

ELIGIBILTY:	Are you an active employee and making monthly contributions to TRS? ☐ Yes ☐ No If no, are you regularly scheduled to work 10 or more hours per week? ☐ Yes ☐ No	(If no to both, you are not eligible for TRS-ActiveCare coverage)

SECTION 1: ENROLLMENT/CHANGE TRANSACTION TYPE

☐ Annual Enrollment ☐ New Employee ☐ Add Dependent ☐ Special Enrollment

☐ **For New Employee** (check one): ☐ Effective on Actively at Work ☐ Effective 1st day of month following

Special Enrollment Event Date: ___ / ___ / ___ ☐ Marriage ☐ Court Order ☐ Birth/Adoption ☐ Loss of Coverage ☐ Other:

Change Only:
☐ Name
☐ Address
☐ Plan/Coverage

Decline Coverage:
☐ Yes (Complete Section 6)
☐ N/A

Effective Date of Change/Cancel ___ / ___ / ___

Cancel Employee
☐ Death
☐ Loss of Eligibility
☐ Retirement/Terminated
☐ Non-Payment
☐ Other: _____

Cancel Dependent
☐ Divorce
☐ Death
☐ Loss of Eligibility
☐ Dropped Coverage
☐ Other: _____

For District Use Only
TRS District #
Actively at Work Date:
Effective/Change Date:
Employer Approval: _____
Were you covered by another district? ☐ Yes ☐ No
If so, which: _____

SECTION 2: EMPLOYEE INFORMATION

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

SECTION 3: COVERAGE SELECTION (Please select a Plan of Coverage and Coverage Type)

PPO Selection: ☐ ActiveCare 1-HD ☐ ActiveCare Select ☐ ActiveCare 2
HMO Selection: ☐ FirstCare ☐ Scott & White Health Plan ☐ Valley Baptist Health Plan
Coverage Type Selected: ☐ Employee Only ☐ Employee + Spouse ☐ Employee + Child(ren) ☐ Employee + Family

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

SPOUSE Last Name: | First Name: | MI:
Street Address: ☐ Same as Employee
City: | State: | Zip: | Phone Number:
Sex: ☐ M ☐ F | Date of Birth: | Social Security #:
Other Insurance: ☐ Yes. Carrier/Plan ☐ No ☐ Medicare: ☐ Part A ☐ Part B ☐ Part C ☐ Part D

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

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

PLEASE CONTINUE ON NEXT PAGE

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

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

SECTION 5: DISABLED DEPENDENTS OVER AGE 26

☐ Dependent Child's Statement of Disability Attached

Please note that a Dependent Child's Statement of Disability form is required for coverage of a disabled child over age 26. See your Benefits Administrator for the form, which must be completed in full and submitted to your Benefits Administrator.

SECTION 6: DECLINATION OF COVERAGE

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

Name:	SSN:	☐Employee	Reason:	☐Other Coverage	☐Other:
Name:		☐Spouse	Reason:	☐Other Coverage	☐Other:
Name:		☐Child	Reason:	☐Other Coverage	☐Other:
Name:		☐Child	Reason:	☐Other Coverage	☐Other:
Name:		☐Child	Reason:	☐Other Coverage	☐Other:
Name:		☐Child	Reason:	☐Other Coverage	☐Other:

SECTION 7: COVERAGE CONDITIONS

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

Applicant Signature: X _____ Date: _____

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