

NOTICE TO EMPLOYEE (NON-EXEMPT/CLASSIFIED ONLY)
Labor Code Section 2810.5

Employee Name: _____

Start Date: _____

EMPLOYER

Employer Name (Official Catholic Directory Name of Location): Archdiocese of Los Angeles

Employer DBA (Name on Payroll Checks if different from above): _____

Address: 3424 Wilshire Blvd. Los Angeles, CA 90010

Telephone Number: 213 637-7000

WAGE INFORMATION

Rate(s) of Pay: \$ _____ (identify each rate if employee is paid at different rates for different duties)

Overtime Rate(s): _____ (= 1.5 x rate for hours worked over 8 and less than 12 in a day or for more than 40 in a week or for the first 8 hours of the 7th consecutive day worked in a week); _____ (= 2x rate for hours worked over 12 in a day, or more than 8 on the 7th consecutive day worked in a week)

Rate by (check box): ☒ Hour ☐ Shift ☐ Day ☐ Week ☐ Salary ☐ Piece rate ☐ Commission

☐ Other (provide specifics): _____

Dollar value of meal(s) or lodging provided by employer that is considered part of employee's wage: _____

(Signing the acknowledgment of receipt below does not constitute a "voluntary written agreement" as required by law in order to credit any meals or lodging against the minimum wage. Any such voluntary written agreement must be a separate document.)

Regular Payday: Bi-Weekly (e.g., bi-weekly [every 2 weeks] on Fridays; bi-monthly [twice a month] on 1st and 15th of the month)

PAID SICK LEAVE

The employer's paid sick leave policy meets and exceeds the requirements of California Labor Code Sections 245-249, which provide that employees who have worked in California at least 30 days in a year may accrue and use a minimum of 3 days of paid sick leave a year. Employees have a right to request and use their accrued paid sick leave. Employees may not be retaliated against for using or requesting the use of accrued paid sick leave and have the right to file a complaint against an employer who retaliates against them. Additional information about the employer's paid sick leave policy is available online at <http://handbook.la-archdiocese.org/chapter-5/section-5-8/topic-5-8-2> and in the employer's policies and procedures which are provided to each employee.

WORKERS' COMPENSATION

The employee's signature on this Notice merely constitutes acknowledgment of receipt

Insurance Carrier's Name: York Risk Services Group, Inc.

Address: P.O. Box 619070 Roseville, CA 95661

Telephone Number: 661-775-9550 Fax: 866-548-2637

Self-Insured (Labor Code Section 3700) ☐ (yes) Certificate Number for Consent to Self-Insure: 1656

ACKNOWLEDGEMENT OF RECEIPT

The Employee's Signature on this notice merely constitutes acknowledgment of receipt.

(PRINT NAME of Employer representative)

(PRINT NAME of Employee)

(SIGNATURE of Employer representative)

(SIGNATURE of Employee)

(Date)

(Date)

Labor Code section 2810.5(b) requires that the employer notify you in writing of any changes to the information set forth in this Notice within 7 calendar days after the time of the changes, unless one of the following applies: (a) All changes are reflected on a timely wage statement furnished in accordance with Labor Code section 226; (b) Notice of all changes is provided in another writing required by law within 7 days of the changes.