

EVERY UNIT, COUNCIL AND DISTRICT PTA
 MUST COMPLETE AND RETURN THIS FORM EVEN IF NO ONE WAS PAID

WORKERS' COMPENSATION ANNUAL PAYROLL REPORT

(Attach insurance premium payment to Report and forward to council/district PTA as directed by their due date. Payment must be received from district PTA on or before January 31)

Name of PTA _____ District PTA _____

Address _____ Council _____

City _____ Zip _____

Please note: List only those employees that PTA pays directly. Attach copies of all DE-6 and DE-542. Do NOT list when monies are donated to school district for employee salaries. Do NOT list company name, only individual names.

	NAME OF WORKER	TYPE OF WORK BE SPECIFIC	DOES PERSON PAID CARRY HIS/HER OWN WORKERS' COMPENSATION INSURANCE?		DATES WORKED JAN 5, 07 - JAN 4, 08	PAYROLL AMOUNT PAID
			YES*	NO		
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						
A	Total Payroll for ALL Employees					0.00
B	Less \$1000					- \$1,000.00
C	Gross Payroll					-1,000.00
D	Premium due for additional Workers' Compensation insurance coverage. 5% of Gross Payroll (Line C)					0.00

*If yes, worker must supply California State PTA with a Certificate of Insurance from his/her Workers' Compensation insurance carrier. This report form must be completed and forwarded through channels to reach the California State PTA office no later than January 31.

- Unit, council and district PTAs are required to file this form **even if no one was paid**.
- Report ALL paid workers -- attach additional Payroll Report detail pages(s) as necessary.
- Attach copies of quarterly employee reporting forms DE-6 and DE-542 for Independent Contractors.
- Write "NO ONE PAID" across form if no one was paid.
- PTA Treasurer or president must sign form.
- Forward through channels (unit to council to district). DO NOT send directly to the California State PTA office.
- Insurance premium received in the California State PTA office after January 31 is subject to a \$25 late fee by California State PTA.
- (See *California State PTA Toolkit*, 5.6.5 "Workers' Compensation Annual Report," for more information.)

Date _____ Signed _____

Telephone _____ Position _____

E-mail _____

FOR COUNCIL/DISTRICT PTA USE ONLY

PAYMENT DATE CHECK NUMBER AMOUNT OF CHECK TOTAL PREMIUM (LINE D) AMOUNT DUE

SIGNATURE (Council/district PTA president or treasurer):