California Community Colleges
Part-Time Faculty Office Hours and Health Insurance Programs Report and Claim Form

Fiscal Year:_____

District: _____

Part-Time Office Hours Program
Number of eligible part-time faculty with office hours: _____
Number of eligible office hours: _____

Total compensation for office hours of eligible part-time faculty: $_____

Part-Time Health Insurance Program
Number of participants: _____

District share of premiums for fiscal year: $ _____

Part-time faculty share of premiums for fiscal year: $ _____

Total cost of premiums paid for fiscal year: $ _____

CERTIFICATION: I hereby certify that the number of eligible participants and the dollar amounts reported above are true and correct to the best of my knowledge.

District Chief Business Officer

_____ _____
Signature Name

_____
Date

For supplemental information, contact:

_____ _____
Name Title

_____
Phone/E-mail

Submit claims to: fiscalstandards@cccco.edu