

**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

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Signature

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Name

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Date

For supplemental information, contact:

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Name

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Title

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Phone/E-mail

Submit claims to: [fiscalstandards@cccco.edu](mailto:fiscalstandards@cccco.edu)