BEST PRACTICES PANEL
HR TOOLKIT

2017

The County Risk Sharing Authority

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A Service Program of the County Commissioners Association of Ohio

IN APPRECIATION

Our HR Toolkit reflects the efforts of many dedicated people to whom we wish to express our appreciation.

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Table of Contents

As a service to member counties, CORSA created the HR Toolkit to assist in the effective application of workplace policies and procedures. The sample forms and documents are just that, samples that should be used as a tool to create and utilize forms or documents that meet the needs of each individual member. Members also have limited legal phone assistance available to them to assist with implementing policies and related forms within the county. Please contact Frank Hatfield at (614) 221-1216 for assistance. Should you have any questions regarding the Toolkit feel free to contract John Brownlee at jbrownlee@ccao.org or call him at (419) 428-2189.

Section I

Discipline and Termination

(AGENCY)

PERFORMANCE EVALUATION FOR RESERVES

Reserve Name _____

Division _____

Average Score _____

Date Inclusive_____**through** _____

Date of Reserve Conference_____

EXPLANATORY SECTION

The following information is intended to aid the evaluator when filling out an evaluation form. Please take the time to become familiar with the evaluation form and understand all that is expected of you in completing an evaluation form. If you have any questions, contact your supervisor.

Who performs the evaluations?

The primary supervisor on each shift shall complete the evaluation form. If, because of shift rotations or work assignment changes two or more supervisors directed the employee during the appraisal period, all the supervisors should collaborate on the evaluation, even though only the current supervisor may meet with the employee.

Other types of appraisal may be used but are strictly optional. These include self-appraisal where the employee evaluates himself prior to meeting with the supervisor and the supervisor and the employee review and compare perspectives. The supervisor, however, makes the final determination. Peer appraisal is another option. The supervisor may seek the input of employees who work directly with the employee being evaluated. Supervisors may want to use subordinate appraisal, where the employees rate the supervisor.

When are comments on the attributes needed?

For any rating other than a "3—meets expectations," an explanatory comment is required. These explanations should include specific accounts of why the employee falls short of expectations or exceeds them. Examples of acceptable and unacceptable comments follow:

Unacceptable:

Carol does good work.
Carol is not dependable.
Carol does not lead by example.

Acceptable:

Every day when I leave the office, I walk past Carol's desk. Everything always seems to be orderly and in place. This behavior has been consistent throughout the year.

I have confided in Carol several times last year about managerial decisions. However, each time she has betrayed this confidence by speaking to the press and coworkers. Also, after each leak, Carol was counseled and documentation was placed in her file.

What are the descriptions on the rating scale used for?

These are used as guides to give the evaluator a better understanding of what is to be expected. The use of the terms such as minimal or excessive should be viewed in relation to departmental averages or norms. The descriptors are offered to provide some consistency in the interpretation.

What is the average score used for at the end of the evaluation?

This average score replaces what was used before as "overall rating." If the employee fails to achieve an average score of 3, that employee will be counseled with written documentation placed in the employee's file. If a trend of falling below what is expected of the employee is established, then disciplinary action is started through progressive action.

If the average score is 4 or above, then a letter of exemplary performance will be issued to the employee. This letter will remain in the employee's personnel file.

How often is the employee evaluated?

The attached form is used for all employees and is to be completed by the supervisor. This evaluation form is then used in the annual review. There are two exceptions with this evaluation system: (1) Probationary employees who are evaluated bi-monthly, and (2) Transfer of the employee from one division to another. When an employee is transferred from one division to another, his or her immediate supervisor evaluates that employee for the time spent under their command. The evaluation form is transferred to the new division commander within thirty days of transfer.

How is the annual review conducted?

Each rater will evaluate the personnel immediately under their supervision. These evaluations will be completed in the month of October of each year.

Duty Position Attendance

Attends meetings, attends special events, maintains minimum hours, attends required training.

Score	Descriptors
1—Below Expectations	Frequently misses meetings. Frequently absent from special events. Misses required hours of training. Does not put in minimum hours.
2—Somewhat Below Expectation	Occasionally misses meetings. Occasionally absent from special events. Misses required hours of training. Does not put in minimum hours..
3—Meets Expectations	Attends required hours of training. Attends meetings as assigned. Attends special events. Present and on time at special events. Puts in minimum hours.
4—Somewhat Exceeds Expectations	Attends required hours of training per year. Volunteers to work extra time. Present and on time at special events.
5—Exceeds Expectations	Attends more than required hours of training per year. Volunteers to work extra time. Present and on time at special events..

COMMENTS: _____

_____

Quality of Work

Demonstrates ability to perform work skills accurately and completely with a minimum of errors. Complies with departmental rules, policies and standards.

Score	Descriptors
1—Below Expectations	Work is consistently late, inaccurate and incomplete. Important assignments are overlooked.
2—Somewhat Below Expectation	Work is occasionally late, inaccurate, and incomplete. Important assignments are occasionally overlooked.
3—Meets Expectations	Work is accurate, complete, and organized.
4—Somewhat Exceeds Expectations	Work is accurate, complete, and organized. Suggests alternative ways to complete assignments that are more efficient.
5—Exceeds Expectations	Work shows a high degree of thoroughness and accuracy. Reviews work results and makes revisions to improve quality. Suggests and develops alternative ways to complete tasks which save time and resources.

COMMENTS: _____

_____

Written Communication Skills

Demonstrates the ability to complete forms or other job-related reports in a clear and concise written style. Written communications and correspondence is organized, easy to follow, and appropriate.

Score	Descriptors
1—Below Expectations	Forms and reports consistently contain numerous errors and are incomplete. Reader has much difficulty understanding the contents of the report. Written communications usually require correction and clarification.
2—Somewhat Below Expectation	Forms and reports occasionally contain errors and are occasionally incomplete. Although the report may be disorganized, the reader is able to understand the content. Occasionally requires correction and clarification.
3—Meets Expectations	Forms and reports are predominantly correct, complete, and easy to understand. Rarely requires correction and clarification.
4—Somewhat Exceeds Expectations	Forms and reports are correct, complete, and easy to understand. No corrections or clarification is needed.
5—Exceeds Expectations	Forms and reports are correct, complete, and easy to understand. No corrections or clarification is needed. Provides detailed descriptions.

Care of Equipment and Workplace

Demonstrates proper use and care of all county-owned equipment. Maintains clean and orderly work place.

Score	Descriptors
1—Below Expectations	Demonstrates a general careless attitude towards county equipment and work place that interferes with ability to complete assignments.
2—Somewhat Below Expectation	Demonstrates a general careless attitude toward county equipment and work place, but is able to complete assignments.
3—Meets Expectations	Almost always avoids unnecessary waste, wear, or damage to equipment. Workspace is neat and clean.
4—Somewhat Exceeds Expectations	Demonstrates care with all county-owned equipment. Maintains an organized work area that enhances his/her ability to complete assignments in a timely and efficient manner.
5—Exceeds Expectations	Demonstrates care with all county-owned equipment. Maintains an organized work area that enhances his/her ability to complete assignments in a timely and efficient manner. Offers suggestions that enhance the tidiness and neatness of the organization. Utilizes equipment in a cost efficient manner.

COMMENTS:_____

_____

Professional Ethics

Follows through with commitments. Demonstrates loyalty to the County organization.

Score	Descriptors
1—Below Expectations	Speaks against mission statement. Exhibits low professional ethics.
2—Somewhat Below Expectation	Occasionally speaks against mission statement.
3—Meets Expectations	Generally follows through with commitments. Exhibits accepted professional ethics.
4—Somewhat Exceeds Expectations	Has a high level of commitment and is a good representative of the Employer.
5—Exceeds Expectations	Promotes mission statement. Represents organization in an outstanding manner in the community and the County. Exhibits high personal ethics.

COMMENTS:_____

_____

Interpersonal Skills

Provides ongoing feedback and supports co-workers. Demonstrates the ability to be consistently responsive to the needs and concerns of public, subordinates, peers and superiors. Includes receptivity to suggestions from others in a non-disruptive fashion.

Score	Descriptors
1—Below Expectations	Argumentative and disruptive. Usually a poor listener. Sometimes discourteous to the public.
2—Somewhat Below Expectation	Negative approach to workers, fellow employees, and public.
3—Meets Expectations	Gets along with co-workers, supervisors, and is courteous to the public.
4—Somewhat Exceeds Expectations	Positive approach to work, employees, and public.
5—Exceeds Expectations	Always has a positive and helpful attitude towards work and the public.

COMMENTS: _____

_____

Appearance

The personal impression an individual makes on others as determined by the respective department's standards. (Consider cleanliness, grooming, neatness, and appropriateness of dress on the job.)

Score	Descriptors
1—Below Expectations	Very untidy, lacking hygiene, does not maintain clean uniform or clothing. Shoes/brass need polished.
2—Somewhat Below Expectation	Sometimes untidy and careless about personal appearance.
3—Meets Expectations	Generally neat and clean; satisfactory personal appearance. Clothing/uniform is pressed. Shoes, brass, and web gear are clean and polished.
4—Somewhat Exceeds Expectations	Careful about personal appearance. Dresses appropriately for position and situation.
5—Exceeds Expectations	Unusually well groomed; very neat. Always dresses appropriately for position and situation. Never needs to be told to clean uniform/clothing or to polish brass or shoes.

COMMENTS: _____

_____

Decision-Making Skills

Makes sound, timely decisions, Uses discretion and sound judgment in safeguarding of confidential information. Demonstrates use of common sense, resourcefulness, or originality in handling or resolving non-routine, work-related problems.

Score	Descriptors
1—Below Expectations	Indecisive. Cannot determine what information is needed to make a decision.
2—Somewhat Below Expectation	Will ask for assistance when the answer is obvious.
3—Meets Expectations	Able to collect pertinent information in making a decision. Demonstrates common sense.
4—Somewhat Exceeds Expectations	Makes a decision when the solution is obvious. Will ask for a decision when answer is not clear.
5—Exceeds Expectations	Almost always collects pertinent information in making a decision. When appropriate, uses participative decision-making style. Makes a timely decision when appropriate.

COMMENTS: _____

_____

Oral Communications Skills

Communicates in an open, candid, consistent manner. Presents verbal ideas and issues in their simplest form. Ability to express ideas clearly and concisely, give instructions, state and relay information. Receives and sends messages to the public appropriately.

Score	Descriptors
1—Below Expectations	Constantly requests clarification or requires repeated instructions.
2—Somewhat Below Expectation	Frequently requests repeated clarification or instruction.
3—Meets Expectations	Asks for clarification when direction is unclear. Accurately communicates instruction to others.
4—Somewhat Exceeds Expectations	Seldom requires clarification or instruction.
5—Exceeds Expectations	Always speaks clearly and concisely. Demonstrates an ability to interpret what people are saying and additional communications skills.

COMMENTS:_____

_____

Job Knowledge

Score	Descriptors
1—Below Expectations	Work is predominantly completed with errors due to lack of knowledge of policies, procedures, rules and regulations. Fails to acquire or seek clarification of policies.
2—Somewhat Below Expectation	Occasionally completes work with errors due to lack of knowledge of policies, procedures, rules and regulations. Seeks clarification when uncertain.
3—Meets Expectations	Rarely completes work with errors due to lack of knowledge of policies, procedures, rules and regulations. Seeks clarification when uncertain. Demonstrates knowledge of policies, procedures, and use of equipment required to complete assigned tasks related to his/her position.
4—Somewhat Exceeds Expectation	Applies skills and knowledge in a thorough and comprehensive manner. Utilizes organizational and literature resources to research and analyze work-related problems.
5—Exceeds Expectations	Demonstrates mastery over all skills required for his/her position. Utilizes organizational and literature resources to research and analyze work- related problems. Seen by others as an expert and resource.

COMMENTS:_____

_____

OPEN-ENDED QUESTIONS

Identify your strengths and competencies. _____

_____

_____

What development needs do you perceive? _____

_____

_____

What training would you like to obtain this year? _____

_____

_____

Indicate your career track, what interests you the most? _____

_____

_____

Employee's Goals and Objectives: _____

_____

_____

Employee Comments: _____

_____

_____

SIGNATURE PAGE

AVERAGE SCORE _____

Signature of Employee: _____

Date

Signature of Evaluator: _____

Date

Signature of Director: _____

Date

Signature of Appointing Authority: _____

Date

ADMINISTRATIVE LEAVE SAMPLE LETTER

[date]

Name
Address
City, State Zip

RE: Administrative Leave

Dear_____:

Please be advised that [name of employer] is conducting an investigation into allegations of potential misconduct. Consequently, you are hereby placed on paid administrative leave pursuant to [policy or contract section, if applicable]. Your placement on paid administrative leave is effective immediately and shall continue until the completion of the investigation.

During the period of paid administrative leave, you are required to remain available to answer any inquiries between the hours of (normal working hours). You are not to come on the premises or contact [name of employer] employees during their working hours absent prior approval by [name of supervisor]. You are not to disclose any details of the investigation to any party, other than a personal legal representative or union representative. Similarly, you are not to conduct any work for, or otherwise hold yourself out to represent the, [name of employer] absent prior approval from [supervisor].

If you have any questions or comments, please do not hesitate to contact [name of supervisor].

Sincerely,

ADMINISTRATIVE PROCEEDINGS RIGHTS

You are to be advised of the following:

1. Any admission made in the course of this internal investigation may be used as the basis for charges seeking your removal, discharge or suspension.

2. You have the right to have a representative of your choosing to be present with you at this hearing, interrogation or examination and you may consult with him/her. However, the representative has no right to speak at the interview.

3. You will be given a reasonable time to obtain a representative of your own choosing.

4. You have no right to remain silent. You will truthfully and completely answer questions. You are advised that your statements or responses constitute an official internal investigation. You will be asked questions specifically directed and narrowly related to the performance of your official duties or fitness for office. This investigation should not in any way be construed as a criminal investigation.

5. If you refuse to answer questions, you will be ordered by a superior officer to answer the questions.

6. If you persist in your refusal to answer questions after the order, you are advised that such refusal constitutes insubordination and a violation and will serve as a basis for your discharge.

7. You are further advised that by law any admission made by you during the course of this hearing, interrogation or examination cannot be used against you in a subsequent criminal proceeding.

The undersigned hereby acknowledges that he/she was informed of the above rights.

_____

SIGNATURE

WITNESSES

_____

_____

_____

DATE:_____TIME: _____

INTERNAL COMPLAINT FORM

1. Name of complainant: _____

   Position title (if employee): _____

   Address (if non-employee): _____

   _____

2. Date of Incident: _____

3. Is this a complaint of discrimination and/or harassment? If so, please tell us the type of discrimination/harassment alleged (check all that apply):

   ☐Racial ☐Religious ☐Sex ☐National Origin

   ☐Color ☐Disability ☐Age ☐ Harassment

   ☐Other, please explain: _____

   _____

   _____

4. Name(s) of individual(s) involved in the alleged incident:

   _____

   _____

5. What occurred? Describe the nature of your complaint (add attachment if more space needed):

   _____

   _____

   _____

   _____

6. Where did the incident occur?_____

7. Please describe any adverse employment action which you believe has resulted from the alleged incident, if any: _____

_____

_____

_____

8. Potential Witnesses:

_____

_____

_____

9. Are there any other incidents involving this individual in which you either witnessed or were involved?

_____

_____

_____

10. What remedy are you requesting?

_____

_____

_____

_____ _____

Name Date

County Risk Sharing Authority of Ohio (CORSA)

Top Ten Employment Topics To Train Your Employees On

Whether it be conducted to promote a more happy and efficient workplace, or to manage the risk of lawsuits, it is imperative to regularly conduct training in the areas of employment law with your staff, managers, and human resource professionals. This training should be conducted in addition to the distribution of written employment policies to all employees at the time of their hire. In response to several requests from our members, and based upon our experience, we provide the below table which sets forth the top ten employment topics about which we recommend regular training, as well as the frequency of such training.

	Staff	***Managers***	***H.R.***
• **Non-harassment, non-discrimination, and non-retaliation:** (1) prohibition and reporting mechanism for staff, (2) enforcement for managers/H.R.	Annually	Annually	Annually
• **Family Medical Leave Act / Americans with Disabilities Act**	N/A	Annually	Annually
• **Workplace Safety** (including state OSHA regulations)	Annually *for safety sensitive* Every 3 years *for non-safety sensitive*	Annually *for safety sensitive* Every 3 years *for non-safety sensitive*	Annually
• **Fair Labor Standards Act**	N/A	Biennially	Biennially
• **Substance Abuse Detection/Prevention**	Biennially	Biennially	Annually
• **Civil Service Law** (including unclassified designations and statutory leaves)	N/A	Every 2-3 yrs	Biennially
• **Diversity, Inclusion, and Conflict Management**	Every 2-3 yrs	Every 2-3 yrs	Every 2-3 yrs
• **Bureau of Workers Compensation matters**	N/A	N/A	Biennially
• **Personnel Records** (including records retention schedules and application of public records law)	N/A	Every 2-3 yrs	Biennially
• **Hiring, discipline, evaluations, and promotions of employees**	N/A	Every 2-3 yrs	Biennially

All questions and requests for assistance with regard to the above recommended training are welcome and should be directed to: CORSA Risk Control Manager John Brownlee, ARM-P at (419) 428-2189/jbrownlee@ccao.org.

CHECKLIST FOR DISCIPLINE OF CLASSIFIED EMPLOYEES

There are Sufficient Articulable Facts to Support a Disciplinary Action

- There has been an adequate investigation.
- There is documentation to support discipline.

The Employee was Afforded a Pre-Disciplinary Conference Prior to the Disciplinary Decision

- The employee was given a notice of the charges and an opportunity to respond.
- The employee was afforded a right to have an attorney present at the conference.
- If applicable, the employee was afforded a right to a Union representative at the conference.

An O.R.C. 124.34 Order was Properly Served and Filed

- SPBR form ADM 4055 should be used: http://pbr.ohio.gov/pdf/124-34OrderFillin.pdf.
- The form must state the statutory reason (category) for the discipline: as contained in

O.R.C. 124.34.

- The form must advise the employee of the right to appeal. The second page of the SPBR form advises the employee of the right to appeal.
- **Two copies of the form must contain original signatures of the appointing authority.**

Service Upon the Employee of Discipline

- One copy of the form containing the original signatures of the appointing authority must be served upon the employee.
- The employee must be served on or before the effective date of the disciplinary action.
- The employee may be served by personal delivery, certified mail return receipt requested, or by leaving it at the employee's usual residence with an adult.
- If served by mail, the service is complete when the return receipt is signed by the employee.
- Follow instructions on SPBR form ADM 4055
- Appointing authority must maintain an original

FLOW CHART FOR DISCIPLINE OF NON-UNION PUBLIC EMPLOYEES

Receive information that misconduct has occurred

↓

Conduct investigation into the truthfulness and accuracy of reports* (Garrity, Piper)

↓

Determine whether evidence exists that the misconduct actually occurred

↓

Determine the charges that apply to the employee's misconduct – Keep in mind the employee's constitutional rights (*e.g.* Speech, Religion, Association)

↓

Send notification of the charges to the employee and schedule a pre-disciplinary conference where the employee will have a meaningful opportunity to respond

↓

Conduct the pre-disciplinary conference (Loudermill, Garrity, Piper)

↓

Make a determination of whether discipline is appropriate, and, if so, the amount of discipline that is appropriate.

↓

Notify the employee of the sanction

↓

File a § 124.34 Order.

<u>*Investigation may involve</u>:

- Examination of reports
- Interview of Witnesses
- Interview of the Employee
- Surveillance
- Review of the applicable standard of conduct such as a policy manual
- Other

<u>Probationary Employees</u>

Some of these procedures may be unnecessary for probationary employees. R.C. § 124.27

LAST CHANCE AGREEMENT – CLASSIFIED CIVIL SERVANT SAMPLE LETTER

[DATE]

EMPLOYEE NAME
ADDRESS

RE: Last Chance Agreement

Dear :

You are being offered this LAST CHANCE AGREEMENT in lieu of immediate disciplinary action, which would likely lead to your termination. Pursuant to Ohio Revised Code Section 124.34(E), "a last chance agreement" means "an agreement signed by both an appointing authority and an officer or employee of the appointing authority that describes the type of behavior or circumstances that, if it occurs, will automatically lead to removal of the officer or employee without the right of appeal to the state personnel board of review …." [If you choose not to sign this LAST CHANCE AGREEMENT, a pre-disciplinary conference will be scheduled and discipline will be imposed. / If you choose not to sign this LAST CHANCE AGREEMENT, I will render a decision on your pre-disciplinary conference held on ____, _____.

Description of Misconduct

Your actions constitute a violation of the _____ Employer's policies and work rules constitute cause for discipline in accordance with Ohio Revised Code Section 124.34. Nevertheless, I have determined this LAST CHANCE AGREEMENT shall be offered in lieu of the implementation of further disciplinary action. Pursuant to this LAST CHANCE AGREEMENT, you agree to the following: constitute cause for discipline in accordance with Ohio Revised Code Section 124.34. Nevertheless, I have determined this LAST CHANCE AGREEMENT shall be offered in lieu of the implementation of further disciplinary action. Pursuant to this LAST CHANCE AGREEMENT, you agree to the following:

1. [You shall serve an unpaid suspension of ____(___) days/A suspension of ___(___) days will be placed in your personnel file although you will be required to work during the period of the suspension.]

2. You shall refrain from committing any offense listed in Ohio Revised Code Section 124.34 and any disciplinary offenses as listed in the Employer's Personnel Policies (copies of Ohio Revised Code Section 124.34.

3. [IF APPLICABLE As a condition of continued employment with Employer, you agree to participate in an alcohol/drug treatment program, approved by Employer. You agree to complete any and all therapy, counseling sessions, or other course of action prescribed by a physician or therapist associated with the treatment program. Upon providing proof of successful completion of the prescribed course of therapy, you shall provide Employer with certification of same from the treating physician or therapist.]
4. [IF APPLICABLE You agree that you may be required to submit to random

alcohol/drug testing without any further need for reasonable suspicion on the part of Employer. This paragraph does not prevent Employer from requiring you also to submit to any alcohol/drug test that is based upon reasonable suspicion.]

5. You agree that you will be terminated immediately if any of the following occurs:

    a. [IF APPLICABLE It is demonstrated you have alcohol/drugs in your system during your normally scheduled work hours.]

    b. You engage in any actions that would subject you to discipline under Ohio Revised Code Section 124.34 or the Employer's Personnel Policies and Procedures;

    c. [IF APPLICABLE You fail any alcohol/drug test administered by the Employer or its agents]

    d. [IF APPLICABLE You fail to successfully complete the course of therapy prescribed by a physician or therapist associated with the approved treatment program.]

You will continue to be subject to applicable provisions of Ohio law, including, but not limited to, Ohio Revised Code Section 124.34. You will continue to be subject to the Employer's policies and rules, including, but not limited to, the Employee Handbook. Thus, nothing contained herein constricts the authority of Employer to discipline you in accordance with Ohio law and its policies, up to and including termination, for reasons other than those stated in this LAST CHANCE AGREEMENT.

If you are found to have violated the terms this LAST CHANCE AGREEMENT, you will be immediately terminated. If terminated pursuant to the terms of this LAST CHANCE AGREEMENT, you hereby waive any and all rights to appeal, grieve or otherwise challenge your termination, as well as all due process rights including, but not limited to, a pre-disciplinary hearing. While you may appeal a termination under this LAST CHANCE AGREEMENT to the State Personnel Board of Review, that agency will only determine if you violated the terms of this LAST CHANCE AGREEMENT.

_____I UNDERSTAND AND ACCEPT this LAST CHANCE AGREEMENT.

_____I DECLINE this LAST CHANCE AGREEMENT and agree to proceed with disciplinary action at this time.

_____ _____

Employee Signature Date

BY:_____ _____

Employer Date

NOTICE OF LAYOFF/ABOLISHMENT

Dear :
_____

This is to inform you that you are being laid off from your position of _____ _____ due to (lack of work, lack of funds or job abolishment). Your retention points have been calculated as ____. This lay off is effective fourteen (14) days from the date of this letter or is hand-delivered or 17 days after being sent certified mail return receipt requested.

You may have the ability to displace an employee who has fewer retention points in a lower classification. You must advise in writing within five (5) days of the date of this letter if you wish to exercise any displacement rights you may have.

You may appeal this lay off to the State Personnel Board of Review, 65 E. State Street., 12th Floor, Columbus, Ohio 43215, in writing, filed or postmarked within ten (10) days of the date of this letter.

You will be placed on a recall list and you will retain recall rights for one year from the date of the lay off. During this time it is your responsibility to make sure that the agency has a current address at which you may be contacted. Failure to maintain a current correct address may cause you to lose your reinstatement rights.

If you request it, a copy of O.A.C. 123:1-41 will be provided to you.

Your final pay check will include payment for all earned, unused vacation, personal leave and compensatory time.

PERFORMANCE IMPROVEMENT PLAN

EMPLOYEE: _____ DATE: _____

1. **Define the area for improvement**

2. **Describe the observed performance or behavior:**

3. **Consequences and/or negative impact of performance or behavior. Why does this level of performance not meet the standards for effective practice?:**

4. **What action needs to take place to establish the needed change?**

5. **Detailed objectives to be accomplished:**

Performance Expectation	Date To Be Completed By	Date of Progress Check Meeting	Performance Expectation Met? Y/N	If Expectation Not Met, Identify Next Steps

_____ Date_____

Plan reviewed and accepted by employee:

Employee's Signature

_____ Date _____

Review completed by supervisor:

Supervisor's Signature

_____ Date _____

Performance Plan reviewed by:

Department Manager's Signature

CHECK ONE:

[ ] Performance Plan satisfactorily completed on _____/_____/_____

[ ] Corrective Action Required

Failure to meet and sustain improved performance may lead to further disciplinary action, up to and including termination. Corrective action may be taken in conjunction with, during, or after the performance plan.

NOTICE OF PRE-DISCIPLINARY MEETING

EMPLOYEE NAME

This notice is provided to you to advise that a pre-disciplinary meeting will be held at **TIME at PLACE on DATE** to provide you with an opportunity to respond to the following allegations of misconduct:

(Insert allegations of misconduct here)

You have the right to:
1. Appear at the meeting to present an oral or written statement in response to the charges;
2. Appear at the meeting and have a chosen representative present an oral or written statement in response to the charges; or
3. Elect, in writing, to waive your opportunity to have a pre-disciplinary meeting.

Failure to respond or respond truthfully may result in further disciplinary action.

At the meeting you will have the opportunity to respond to the disciplinary charges. You may present written statements or documents, which you believe, support your position. You may be represented by any person you choose, whether such individual is an employee or not. You do not have the right to call or cross-examine witnesses. No pre-disciplinary meeting will be delayed more than twenty-four (24) hours to enable your representative to attend.

A written report will be prepared after the meeting concluding as to whether or not the alleged conduct occurred. A copy of this report will be provided to you.

The pre-disciplinary meeting will be conducted by _____

If you have any questions in regard to this procedure, please contact _____ immediately.

Employee Acknowledgement: *(initial each applicable statement)*

____ I acknowledge receipt of a copy of this notice

____ I wish to attend the conference as detailed above

____ I wish to waive my right to a Pre-Disciplinary Meeting

Employee Signature: _____ Date: _____

Witness Signature: _____ Date: _____

NOTICE OF PRE-SEPARATION CONFERENCE

This notice is provided to advise you that a pre-separation conference will be held at _____ (time) at _____ (location) on _____ (date) to provide you with an opportunity to respond to the [Employer's] position that substantial credible medical evidence exists indicating that you are incapable of performing the essential functions of a [Job Title] and should be placed on an involuntary disability If it is determined that you are incapable of performing the essential functions of [Job Title] you will be placed on a involuntary disability separation with a right to reinstatement pursuant to OAC §123:1-30-04 [If the Employer has adopted an involuntary disability separation process delete OAC §123:1-30-04 and insert cite Employer policy] for up to two years if substantial medical evidence establishes that you are fit for duty.

You have the right to: (1) appear at the meeting to present an oral or written statement on your behalf; (2) appear at the meeting and have your chosen representative present an oral or written statement on your behalf; (3). examine [Employer's] evidence of your inability to perform the essential functions of the [Job Title] and/or your condition; (4). rebut the evidence; (5). present evidence and/or testimony on your behalf; and/or (6) elect, in writing, to waive your opportunity to have a pre-separation conference. No pre-separation conference will be delayed more than twenty-four (24) hours to enable your representative to attend.

A written report may be prepared after the meeting concluding as to whether or not you are able to perform your essential functions of your position and whether your employment will be separated. If prepared, a copy of this report will be provided to you.

As stated above, at the conference, you have the opportunity to respond to the potential involuntary disability separation. You may be represented by any person you choose.

The pre-separation conference will be conducted by _____.

If you have any questions in regard to this procedure, please contact _____ immediately.

A copy was served via certified mail on ____ on this the _____ day of _____ _____, 20_____.

_____

Service by (date)

WAIVER OF PRE-SEPARATION CONFERENCE

In response to the notification of my potential involuntary disability separation on _____(date), I hereby waive my right to a pre-separation conference.

_____

Employee Signature & Date

State of Ohio
Department of Administrative Services

Order of Removal, Reduction, Suspension, Fine, Involuntary Disability Separation

M__ _____

This will notify you that you are; ☐ removed; ☐ suspended; ☐ suspended (working); ☐ fined;

☐ involuntary disability separated; ☐ reduced in pay, from your position of

_____ and/or reduced to new position of _____
(if applicable)

effective _____
(date)

The reason for this action is that you have been guilty of (List relevant R.C. 124.34 disciplinary offense(s)).
(Section not applicable for involuntary disability separation.)

Specifically:

Notice of pre-disciplinary/separation hearing given to employee: _____
(date)

Pre-disciplinary/separation hearing held or waived: _____
(date)

Employee allowed to meet with employer: ☐ Yes ☐ No

Order hand-delivered to employee: _____
(date, if hand-delivered)

If employee is suspended, list dates of suspension: _____

Signed at _____ Ohio, _____
(city) (date)

Counter signature, if applicable	Signature of Appointing Authority
Counter signature, if applicable	Type Name and Title of Appointing Authority
Counter signature, if applicable	Type Department, Agency, or Institution

ADM 4055 (Rev. 6-99)/PDF

Important: See attachment for Employer and Employee Instructions.

IMPORTANT INSTRUCTIONS TO THE APPOINTING AUTHORITY

(1) Actual signature means that each Order served on the employee must contain the actual signature of the Appointing Authority. Appointing Authority means the actual appointing officer of the department or agency as well as any approving officer or board required by law. If the appointment of an employee requires the approval of a board or commission, then a certified copy of the resolution of such board or commission approving the action must accompany this Order unless the actual signatures of the members of the board or commission appear on the front of the Order served on the employee.

(2) The Appointing Authority must set forth in detail the particular acts and circumstances constituting the offense(s) charged. Evidence presented on appeal must be limited to that which relates to the charge(s) made; hence the Appointing Authority must set forth the charges(s) broadly enough to encompass all the evidence the Appointing Authority intends to offer. It is equally important that the Appointing Authority fully state the ground(s) for the action.

(3) The Appointing Authority MUST provide an original of the Order to the employee on or before the effective date. The date on which the Order is served is the date the Order is delivered to the employee by hand or to the employee's last known mailing address by certified United States mail, whichever occurs first.

IMPORTANT INSTRUCTIONS TO THE EMPLOYEE

If you wish to appeal this action, then you must file your written appeal with the State Personnel Board of Review (SPBR) at 65 East State Street, 12th Floor, Columbus, Ohio 43215-4213. **Your appeal must actually be received and time-stamped by SPBR by the tenth calendar day from the date this Order was served.** For the purposes of your appeal, the date on which this Order is served is the date the Order is delivered to you by hand or to your last known mailing address, as maintained by your Appointing Authority, by certified United States mail, whichever occurs first. You may obtain SPBR's Administrative Rules by writing the above office or by telephoning SPBR at (614) 466-7046. You may also obtain the rules at SPBR's website at http://pbr.ohio.gov.

Example of deadline to file appeal:

An employee is given a 40-hour suspension. The suspension is to begin on October 11 and run five working days through October 15. The employee is served with the forthcoming suspension Order on October 8. The employee has until October 18 to file a written appeal (ten days from the date the employee was served with the Order).

Reminder: If you are employed by a municipality or township that has a civil service commission, your appeal lies with that commission and not SPBR.

You may contact SPBR at (614) 466-7046 regarding the above information or regarding SPBR's jurisdiction or you may visit our website at http://pbr.ohio.gov.

STATE OF OHIO

STATE PERSONNEL BOARD OF REVIEW

Appellant

Name: _____

Address: _____

City: _____ State: _____ ZIP: _____

Telephone: _____

Email Address: _____

vs.

Appellee

Agency/Dept: _____

Address: _____

City: _____ State: _____ ZIP: _____

Telephone: _____

NOTICE OF APPEAL

Notice is hereby given that Appellant appeals to the State Personnel Board of Review from the Order or Notice of:

Removal	Layoff	Reduction in Pay or Position
Transfer	Abolishment	Fine
Investigation	Reclassification	Involuntary Disability Separation
Other:	Suspension : (☐ one)	Retaliatory Discipline: (☐ one)
_____	Working	Whistleblower
	Non-Working	OSHA
	_____ # of days	

Which was received on (specify date): _____

And which was effective on (specify date): _____

If Applicable

Attorney for Appellant: _____

Address: _____

City: _____ State: _____ ZIP: _____

Telephone: _____Fax: _____

Email Address: _____

TERMINATION CHECKLIST

I. AT TERMINATION

A. Planning for the Termination:

1. Investigate and determine the reasons for the termination decision
2. Policy should explain who is responsible for termination decisions
3. Have all termination decisions thoroughly researched by legal counsel or SPHR
4. Determine if any possible claims exist or problems are present
5. Have two persons present during termination decision
6. Have documentation of decision and outline of exit interview prepared.

B. Severance:

1. Is this needed?
   a. Can avoid litigation when used appropriately.
   b. Consider in all possible ADEA cases.
2. Benefits to employee to consider:
   a. Lump sum or salary continuation?
   b. Pay out sick and vacation?
   c. Reference letter?
   d. Provision for insurance and retirement benefits
   e. Outplacement services?
   f. Company property returned?
   g. Contest unemployment?
   h. Forgiveness of debt?
3. Benefits to Employer:
   a. Waiver of reinstatement and future litigation
   b. Release of any and all claims against company
   c. Confidentiality provision
   d. Non-compete clause?
   e. Non-solicitation clause?
   f. Damages for breach by employee?
4. Always offer time for employee to have legal review of severance conducted (required if employee is over 40)

5. Always have these prepared by legal counsel!

C. Exit Interview

1. Tips:

   a. Be direct and to the point (give business reason for decision)

   b. Advise employee that decision is final

   c. Treat employee fairly and with dignity

   d. Avoid confrontation

   e. Explain benefits (COBRA notice)

   f. Offer/explain severance (if applicable)

   g. Keep meeting short

   h. Include witnesses during interview

D. Unemployment Compensation

1. Remember that you may still incur costs even after an employee is terminated due to the employee's receipt of unemployment compensation.

2. Purpose of Unemployment is to serve as a "safety net" for the unemployed individual who is actively seeking employment. The program is designed to be pro-employee.

3. Unless employer can prove "just cause" for their removal of the employee, the employee will be entitled to benefits.

4. Hearings last 45 minutes

Section II

Discrimination and Harassment

Meeting With: _____Date: _____

Meeting Conducted By: _____

_____

Introduction:

Appreciate EEs time & cooperation.

Nature of what we are investigating.

Matter under investigation is serious, and the department has a commitment/obligation to investigate this claim.

No conclusion will be made until all of the facts have been gathered and analyzed.

Any attempt to influence the outcome of the investigation by discussing it with others, retaliation against anyone who participates, providing false information or failure to be forthcoming can be the basis for corrective action up to and including termination.

Foundation Questions:

1. Who committed the alleged inappropriate behavior?

2. What exactly happened?

3. How did you react?

4. Did you ever indicate that you were offended or somehow displeased by the act or offensive treatment?

5. When did the incident occur or is it ongoing?

6. Where did the incident occur?

7. Who else may have seen or heard the incident?

8. Have you discussed the incident with anyone?

9. How has the behavior affected you and your job?

10. Did you seek any medical treatment or counseling as a result of the incident?

11. When did you first learn of the County's Unlawful Harassment and EEO Policy? (If not provide a written copy of the policy and note below).

12. Is there anyone else who may have relevant information?

13. Do you have any other relevant information?

14. What action do you want the agency/office to take?

INTERNAL COMPLAINT FORM

1. Name of complainant: _____

   Position title (if employee): _____

   Address (if non-employee): _____

   _____

2. Date of Incident: _____

3. Is this a complaint of discrimination and/or harassment? If so, please tell us the type of discrimination/harassment alleged (check all that apply):

   ☐Racial ☐Religious ☐Sex ☐National Origin

   ☐Color ☐Disability ☐Age ☐ Harassment

   ☐Other, please explain: _____

   _____

   _____

6. Name(s) of individual(s) involved in the alleged incident:

   _____

   _____

7. What occurred? Describe the nature of your complaint (add attachment if more space needed):

   _____

   _____

   _____

   _____

7. Where did the incident occur?_____

11. Please describe any adverse employment action which you believe has resulted from the alleged incident, if any: _____

_____

_____

_____

12. Potential Witnesses:

_____

_____

_____

13. Are there any other incidents involving this individual in which you either witnessed or were involved?

_____

_____

_____

14. What remedy are you requesting?

_____

_____

_____

_____ _____

Name Date

Meeting With: _____ Date: _____

Meeting Conducted By:

_____

_____

Introduction:

Appreciate employee's time & cooperation.

Describe what we are investigating.

Matter under investigation is serious, and the department has a commitment/obligation to investigate this claim.

No conclusion will be made until all of the facts have been gathered and analyzed.

Any attempt to influence the outcome of the investigation by discussing it with others, retaliation against anyone who participates, providing false information or failure to be forthcoming can be the basis for corrective action up to and including termination.

Foundation Questions:

- Explain allegations that have been made.
- What is your response to the allegations?
- If you believe the allegations are false, why might the complainant lie?
- Are there any persons who have relevant information?
- Are there any notes, physical evidence, or other documentation regarding the incident(s)?
- Do you know of any other relevant information?

Section III

Ethics-Public Records

Form No. OEC-2016
OHIO ETHICS COMMISSION

FINANCIAL DISCLOSURE STATEMENT

16

This statement is to be filed in **2017**

Financial information for calendar year **2016**

Please type or print clearly. See instructions for assistance with this page.

SECTION A. PERSONAL CONTACT INFORMATION

Last Name | First Name | MI

Address | City | State | Zip

County | E-mail Address | Phone ( )

SECTION B. STATUS (Check all that apply)

- ☐ Candidate
- ☐ Write-in Candidate
- ☐ Elected to an office
- ☐ Appointed to an unexpired term in elective office
- ☐ Public Official
- ☐ Public Employee
- ☐ Voluntary Filer / Other

CANDIDATES: Please list the date of the first election (primary, special, or general) when your name will appear on the ballot.

Month	Day	Year
		2017

FOR OFFICIAL USE ONLY

SECTION C. PUBLIC POSITION, OFFICE, OR JOB

Position/Title (Example: council member, sheriff, board member, or job title)

- ☐ Seeking
- ☐ Hold
- ☐ Held

Public Entity you serve in 2017, served in 2016, or will serve if elected

Public Salary:
- ☐ Uncompensated
- ☐ Less than $16,000
- ☐ $16,000 or more

Start Date: Month | Day | Year

End Date: Month | Day | Year

SECTION D. ADDITIONAL PUBLIC POSITION, OFFICE, OR JOB

Position/Title (Example: council member, sheriff, board member, or job title)

- ☐ Seeking
- ☐ Hold
- ☐ Held

Public Entity you serve in 2017, served in 2016, or will serve if elected

Public Salary:
- ☐ Uncompensated
- ☐ Less than $16,000
- ☐ $16,000 or more

Start Date: Month | Day | Year

End Date: Month | Day | Year

FOR OHIO ETHICS COMMISSION USE ONLY

- ☐ Walk-in
- ☐ Inter Office
- ☐ No Check

Rev'd by:

- ☐ Filer has answered every required question.
- ☐ Filer has not answered these questions:

Date incomplete form returned to filer: _____

Date completed form returned to OEC: _____

1. SOURCES OF INCOME - ALL FILERS MUST ANSWER THIS QUESTION: (For help, see instructions page 4)

☐ I have no sources of income that I am required to list.

Source of Income	Service Provided	Amount* (if required)
A		
B		
C		
D		
E		
* Check instructions to see whether you are required to disclose amounts of income.		

2. SOURCES OF GIFTS - ALL FILERS MUST ANSWER THIS QUESTION: (For help, see instructions page 5)

☐ I have no sources of gifts that I am required to list.

Source of Gift	Source of Gift
A	D
B	E
C	F

3. NAMES OF SPOUSE RESIDING IN HOUSEHOLD AND ANY DEPENDENT CHILDREN - ALL FILERS MUST ANSWER THIS QUESTION:

☐ There are no immediate family members whose names I am required to list. (For help, see instructions page 5)

Spouse Residing in Household
Dependent Children

Dependent Children

4. NAMES OF BUSINESSES - ALL FILERS MUST ANSWER THIS QUESTION: (For help, see instructions page 5)

If you or anyone you listed in Question 3 owns or operates a business, list the name of the business.

☐ There are no business names that I am required to list.

Business Name	Business Name
A	C
B	D

5. LAND (REAL ESTATE) IN OHIO - ALL FILERS MUST ANSWER THIS QUESTION: (For help, see instructions page 6)

☐ I have no real estate that I am required to list.

Land (Real Estate) in Ohio (List address or, if address is unavailable, plat number and county)
A
B
C
You are not required to disclose your personal residence or real property held primarily for personal recreation.

6. CREDITORS OVER $1,000 - ALL FILERS MUST ANSWER THIS QUESTION: (For help, see instructions page 6)

☐ I have no creditors that I am required to list.

Creditor	Creditor
A	D
B	E
C	F

7. DEBTORS OVER $1,000 - ALL FILERS MUST ANSWER THIS QUESTION: (For help, see instructions page 6)

☐ I have no debtors that I am required to list.

Debtor	Debtor
A	C
B	D

8. INVESTMENTS OVER $1,000 - ALL FILERS MUST ANSWER THIS QUESTION: (For help, see instructions page 6 and 7)

☐ I have no investments that I am required to list.

Corporation, Trust, Business Trust, Partnership, or Association	Nature of Investment
A	
B	
C	
D	
E	
F	
IF YOU NEED ADDITIONAL SPACE, PLEASE ATTACH A SEPARATE SHEET.	

9. OFFICES/FIDUCIARY RELATIONSHIPS - ALL FILERS MUST ANSWER THIS QUESTION: (For help, see instructions page 8)

☐ I have no offices or fiduciary relationships that I am required to list.

Corporation, Trust, Business Trust, Partnership, or Association	Office or Nature of Relationship
A	
B	

SKIP QUESTIONS 10 AND 11 IF YOU ARE ONLY REQUIRED TO FILE AS A:

- College or university trustee
- Candidate for a city, township, school district, or ESC position that is paid less than $16,000 a year
- City, township, school district, ESC, or sanitary district official or employee serving in a position that is paid less than $16,000 a year

10. FOOD OR BEVERAGES - ALL FILERS EXCEPT THOSE LISTED IN THE BOX ABOVE MUST ANSWER THIS QUESTION:

☐ I have no sources of meals, food, or beverages that I am required to list. (For help, see instructions page 8)

Source of Food or Beverages	Source of Food or Beverages
A	C
B	D

11. TRAVEL EXPENSES - **ALL FILERS EXCEPT THOSE LISTED IN THE BOX ON PAGE 3 MUST ANSWER THIS QUESTION:**

☐ I have no sources of travel expenses that I am required to list. (For help, see instructions page 9)

Source of Travel Expenses	Amount
A	
B	
C	
D	
E	
F	

12. NON-DISPUTED INFORMATION - **ALL state employees, state officials and state board and commission members (except college and university trustees) are REQUIRED to answer Question 12.** All other filers should skip this question and go to question 13.

☐ I have no information that I am required to list. (For help, see instructions page 9)

Non-Disputed Information
A
B

13. SIGNATURE - **ALL FILERS MUST SIGN THE STATEMENT:** (For help, see instructions page 10)

By signing this statement:

- I swear or affirm that this statement and any additional attachments have been prepared or carefully reviewed by me, and constitute my complete, truthful, and correct disclosure of all required information, and that the address listed on page 1 is a correct mailing address.
- I acknowledge and understand that, among other potential violations and penalties, knowingly filing a false statement is a criminal misdemeanor of the first degree, in violation of Sections 102.02(D) and 2921.13(A)(7) of the Revised Code, punishable by a fine of not more than $1,000, imprisonment of not more than six months, or both.
- I acknowledge and understand that filing a false statement may be grounds for removal from public office or dismissal from public employment pursuant to Sections 3.04 and 124.34 of the Revised Code.
- I acknowledge that, in 2016, I served in, or in 2017, I am serving in or a candidate for, the position indicated on page 1 of this statement.

If you have any questions before signing this form, please contact the Ohio Ethics Commission at (614) 466-7090.

Before signing this statement, please review to make sure that you have answered each question you are required to answer. If you have nothing to list in response to any question, check the box indicating that you have nothing to list. If the response to any required question is omitted, the Commission will return the statement to you as incomplete. **Any person who fails to file a complete statement by the appropriate filing deadline will be assessed a late filing fee and may be subject to criminal penalty.**

Deliver completed statement to: Ohio Ethics Commission, 30 W. Spring St., L3, Columbus, OH 43215

My filing fee is: (For help, see instructions page 2)

☐ Enclosed (check or money order payable to "Ohio Ethics Commission")
☐ Submitted Online
☐ Included in my attorney registration fees (Judges, Magistrates, and Judicial Candidates Only)
☐ My public agency is required or has agreed to pay my filing fee.

YOUR SIGNATURE IS REQUIRED HERE: _____ **Date:** _____

Rev. 01-2017

OHIO ETHICS COMMISSION FORM NO. OEC-2016
FINANCIAL DISCLOSURE STATEMENT INSTRUCTIONS

PURPOSE OF FINANCIAL DISCLOSURE AND REQUIREMENT FOR DISCLOSURE

Filing a financial disclosure statement is part of the responsibility of choosing to hold or run for public office or employment. The purpose of requiring public officials and employees to file financial disclosure statements is to increase confidence in government and openness by: (1) Assisting public servants in identifying potential conflicts of interest; and (2) Allowing citizens to become aware of the financial interests of the officials and employees who serve them.

Filing an annual financial disclosure statement is required by law and Commission rule. [For more information on positions required to file by Commission rule, click here.] Financial information must be completed for the entire preceding calendar year. A person who leaves a filing position must file for the last calendar year in which he or she held the position. No person is required to file more than one statement for any calendar year.

Electronic filing is available at disclosure.ethics.ohio.gov

WHO IS REQUIRED TO FILE A FINANCIAL DISCLOSURE STATEMENT?

Anyone who is elected, appointed to, or a candidate for the following elective offices:

- State elective office
- County elective office
- City elective office
- State Board of Education
- School district board of education (in districts with a total student count of 12,000 or more)
- Educational service center (ESC) governing board in an ESC with a total student count of 12,000 or more

Candidates for office should note that this financial disclosure statement is NOT the same as a campaign finance report that is filed with the Secretary of State's Office or county board of elections. This statement must be filed regardless of whether the candidate raised or spent money for his or her campaign.

Anyone who is appointed to the following non-elective public positions:

- Member, state board or commission
- Appointed member, State Board of Education
- Trustee, state college or university
- Member, state retirement system board
- Appointed member, ESC governing board in an ESC with a total student count of 12,000 or more

Anyone who is employed in these public positions:

- State department director, assistant director, deputy director, or division chief
- Person in an equivalent rank to the above state department employees
- Chief executive officer of a state board, commission, or retirement system
- All state retirement system investment officers
- All professional employees of the Casino Control Commission
- All technical employees of the Casino Control Commission who perform an internal audit function
- Administrator, Director of Investments, and Chief Investment Officer, Bureau of Workers' Compensation
- State employees paid under Schedule "E-2" or "C"
- President, State college or university
- Superintendent, Treasurer, or Business Manager, school district or ESC

Other Filing Categories: Other filers include members and employees of JobsOhio, entrepreneurs in residence assigned by the LeanOhio office, members of some sanitary districts, and directors of community based correctional facilities.

OHIO ETHICS COMMISSION FORM NO. OEC-2016
FINANCIAL DISCLOSURE STATEMENT INSTRUCTIONS

FILING DEADLINES:

The disclosure statement must be received by the Commission, or have a U.S. postmark or date from a commercial delivery service, by the applicable deadline. The filing deadline for disclosure statements is **MONDAY, MAY 15, 2017**, unless you are filing for any of the following reasons:

Candidates: The disclosure statement is due for most candidates thirty days before the first primary, special or general election when their names will be on the ballot. For write-in candidates, the statement is due twenty days before the first primary, general, or special election when their candidacy is to be voted on. For example:

Candidate in the May 2, 2017, primary election	Monday, April 3, 2017
Write-in candidate in the May 2, 2017, primary election	Wednesday, April 12, 2017
Candidate in the November 7, 2017, general election (who has not already filed as an incumbent or primary candidate)	Tuesday, October 10, 2017
Write-in candidate in the November 7, 2017, general election (who has not already filed as an incumbent or primary candidate)	Wednesday, October 18, 2017

Person Appointed to Unexpired Term in Elected Office: Within 15 days after being sworn in to office.

Person Appointed or Promoted to, or Employed in, a Non-Elective Filing Position after February 15, 2017: Within 90 days of appointment, promotion, or employment.

FILING FEES:

Disclosure statements must be accompanied by a filing fee based on the position for which the person is filing.

State elected office holder or candidate	$ 95.00
State Board of Education member or candidate	$ 35.00
County elected office holder or candidate	$ 60.00
City elected office holder or candidate	$ 35.00
School district board of education member or candidate	$ 30.00
ESC governing board member	$ 30.00
School district or ESC superintendent, treasurer, or business manager	$ 30.00
All other filers	$ 60.00

Filing fees can be paid by check or money order made payable to the Ohio Ethics Commission.

LATE FEES:

Any person who files the disclosure statement after the appropriate deadline is required to pay a late fee of $10 a day for each day the statement is late. The maximum late fee is $250.

FAILURE TO FILE A DISCLOSURE STATEMENT OR FILING A FALSE DISCLOSURE STATEMENT:

Any person who fails to file a disclosure statement or who files a false statement may be subject to prosecution. R.C. 102.02(C) makes it a fourth-degree misdemeanor to knowingly fail to file a disclosure statement that is required by law. R.C. 102.02(D) and 2921.13(A)(7) make it a first-degree misdemeanor to knowingly file a false disclosure statement.

PUBLIC RECORDS:

Once filed, every disclosure statement is a public record. Most statements and their attachments are available for public inspection. For security purposes, filers should NOT list or attach any of the following to their disclosure statements: (a) social security numbers; (b) account numbers for bank, credit card, or investment accounts; or (c) IRS documents or filings.

For more information, please visit ethics.ohio.gov or call (614) 466-7090. 2

STEP-BY-STEP INSTRUCTIONS

Electronic filing is available at disclosure.ethics.ohio.gov

SECTION A—PERSONAL CONTACT INFORMATION:
Fill in your name, preferred mailing address, county, phone number, and e-mail address. Your e-mail address will be used to provide you with updates and notices about financial disclosure filings.

SECTION B—STATUS:
Check all of the appropriate boxes indicating your status—the reason you are filing this statement. For example, if you are a county elected official who is running for a city elected office, you would check the box for "Candidate" and the box for "Elected to an office."

Check "Public official" if you are filing a disclosure statement because you have been appointed to a public board or commission (such as a state board, university board of trustees, or board of a sanitary district).

Check "Public employee" if you are filing a disclosure statement because you are an employee of a state or local public agency (such as a state department director, retirement system investment officer, or school district superintendent).

If you are a candidate, please list the date of the first primary, special, or general election in 2017 when your name will appear on the ballot. If you are a write-in candidate, list the date of the first election at which voters can write in your name on the ballot.

SECTION C—PUBLIC POSITION, OFFICE, OR JOB: Information about the public position for which you are filing a disclosure statement.

List your public position or title, such as council member, sheriff, board member, or department director.

List the public entity that you serve in 2017, served in 2016, or will serve if elected. For example, if you are a city council member, list the name of the city. If you are a county sheriff, list the name of the county. If you are a board member, list the name of the board. If you are a department director, list the name of the department.

If you are a candidate seeking the position, check the "Seeking" box. If you are currently serving, check the "Hold" box.

If you served in 2016 or 2017, and are no longer serving, check the "Held" box.

Indicate whether the position you hold, held, or are seeking is uncompensated, or check the box next to the salary category paid for service in the position.

List the start date for the position you hold. If you are an elected official, list the start date for the current term. If you were appointed to an unexpired term in an elected office, your start date is the date you were sworn in to the office. List the end date for the position if there is an end date.

SECTION D—ADDITIONAL PUBLIC POSITION, OFFICE, OR JOB:
If you are required to file a disclosure statement for more than one public position, provide information for the other public position here. If you are not required to file a disclosure statement for more than one public position, skip Section D.

OHIO ETHICS COMMISSION FORM NO. OEC-2016
FINANCIAL DISCLOSURE STATEMENT INSTRUCTIONS

QUESTION 1—SOURCES OF INCOME: For more information, check out FAQs on Income

"Income" includes:

1. "Gross income" as defined in the federal Internal Revenue Code (26 USC 61); and
2. Interest and dividends on all governmental securities, whether federal, state, or local.

Examples of "gross income" include compensation for services (such as salary), interest, rent, and pensions.

Most filers* must list every source of income, regardless of amount, that: (a) they received in 2016; or (b) any other person received in 2016 for their use or benefit. Following each source of income, briefly describe the services you provided in return for the income.

Another person has received income for your "use or benefit" if the source's purpose for giving compensation to that person is to provide it for your use or for your benefit. For example, if you are a beneficiary of a trust, the trust earns income for your use or benefit. You must list the trust as a source of income and all sources of income received by the trust. For more information about trust disclosure, see Advisory Opinion No. 2005-01.

If you are paid for your public service, include the public agency as a source of income.

You are **not required** to disclose:

A. Your spouse's income sources (although you may benefit from your spouse's income, he or she usually does not receive income for the purpose of providing it to you [see Advisory Opinion No. 75-036]); or
B. The names of clients, patients, or customers of your business or practice (simply disclose the business or practice).

Amount of Income: You must also disclose the amount of income you received from any source, IF:

1. The source is doing or seeking to do business with the public agency you serve; or
2. You earned the income because you provided goods or services to a legislative agent (lobbyist). [See R.C. 101.70 or contact the Joint Legislative Ethics Committee for a list of registered lobbyists.]

EXAMPLES:

	Source of Income	Service Provided	Amount* (if required)
A	Your Employer(s)	Your position(s)	
B	Smith & Jones Co., L.P.A.	Private law practice	
C	Your Pension Fund	Retirement	
D	XYZ Corporation	Stock dividends	
E	Friendly National Bank	Interest on savings account	$45.00**

** Because this bank is a depository for the filer's public agency, the amount must also be disclosed.

* **NOTE:** These filers disclose only sources of income over $500 and are **not required** to disclose amounts of income:

- College or university trustees;
- Any official or employee of a city, school district, ESC, or sanitary district if his or her public position is paid less than $16,000; and
- Any candidate for an elective office of a city, school district, or ESC if the office is paid less than $16,000.

OHIO ETHICS COMMISSION FORM NO. OEC-2016
FINANCIAL DISCLOSURE STATEMENT INSTRUCTIONS

QUESTION 2—SOURCES OF GIFTS: For more information, check out FAQs on Gifts

Most filers* list every source of a single gift valued at over $75 or multiple gifts with a total value of over $75 that:

A. You personally received in 2016; and
B. Any other person received for your use or benefit in 2016.

Another person has received a gift for your "use or benefit" if the giver's purpose for giving a gift to that person is to provide it for your use or for your benefit. For example, if your spouse has received a gift and the giver's purpose is to provide the gift to you, your spouse received the gift for your use or benefit.

Sources of gifts can include individuals, corporations, or groups of individuals or corporations, such as co-workers, not-for-profit organizations, and trade associations.

You are **not required** to disclose:

A. The nature of the gift;
B. Campaign contributions;
C. Gifts received by will or inheritance or by distribution from a trust established by a spouse or ancestor;
D. Gifts received from any of these family members: spouse, parents, grandparents, children, grandchildren, siblings, nephews, nieces, uncles, aunts, brothers- or sisters-in-law, sons- or daughters-in-law, or parents-in-law; or
E. Gifts from any person to whom you stand in the place of a parent.

*** NOTE:** These filers disclose only sources of gifts valued at over $500:

- College or university trustees;
- Any official or employee of a city, school district, ESC, or sanitary district if his or her public position is paid less than $16,000; and
- Any candidate for an elective office of a city, school district, or ESC if the office is paid less than $16,000.

QUESTION 3—IMMEDIATE FAMILY MEMBER: For more information, check out FAQs on Family Members

List the names of your spouse living in your household and any dependent children.

QUESTION 4—NAMES OF BUSINESSES: For more information, check out FAQs on Business Names

List all names under which you, or any of the immediate family members you listed in response to Question 3, do business. For example, list the name of any business that you or your immediate family members own or operate.

EXAMPLES:

A. You are a partner in a law firm named Smith & Jones. You should list "Smith & Jones."
B. Your spouse who lives with you has an accounting firm called Ace Accounting. You should list "Ace Accounting."
C. Your dependent child mows lawns under a business called Carl's Lawn Service. You should list "Carl's Lawn Service."

QUESTION 5—LAND (REAL ESTATE): For more information, check out FAQs on Real Estate

List all of your leasehold and ownership interests in land and real estate located in Ohio.

NOTE: Because of an exception in the law, you are **not required** to disclose:

A. Your personal residence; or
B. Any property you use primarily for personal recreation.

QUESTION 6—CREDITORS: For more information, check out FAQs on Creditors

List the name of any person or business residing or transacting business in Ohio to whom you owe, or owed, in 2016, more than $1000 in your own name or in the name of any other person.

For example, if you charged more than $1000 on a credit card during 2016, you must disclose the name of the credit card issuer even if you paid off the card during the grace period.

NOTE: Because of an exception in the law, you are **not required** to disclose a creditor if the debt:

A. Is secured on your personal residence (such as a mortgage or home equity loan);
B. Is secured on real estate used primarily for personal recreation (such as a home equity loan); or
C. Results from the ordinary conduct of your business or profession.

QUESTION 7—DEBTORS: For more information, check out FAQs on Debtors

List the name of anyone residing or transacting business in Ohio who owed you, or any other person for your use or benefit, more than $1000 during 2016.

NOTE: Because of an exception in the law, you are **not required** to disclose as a debtor:

A. A bank or other financial institution if the only money it owes to you is money you deposited with it;
B. Any person who owes you money as a result of the ordinary conduct of your business or profession; or
C. Clients or patients who owe you money if you are a lawyer, doctor, or psychologist.

QUESTION 8—INVESTMENTS: For more information, check out FAQs on Investments and Advisory Opinion No. 2011-01

List the name of each corporation that is incorporated in, or holds a certificate of compliance to do business in, Ohio, and every trust, business trust, partnership, or association that transacts business in Ohio, in which during 2016:

A. You had an investment of over $1000 at any time during the year; and
B. Any other person had an investment of over $1000 for your use or benefit at any time during the year.

You should list any investment you held at any time in 2016, even if you sold or otherwise disposed of it during the year. Briefly describe the nature of each investment you disclose.

EXAMPLES:

	Corporation, Trust, Business Trust, Partnership, or Association	Nature of Investment
A	ABC Growth Fund	Mutual Fund
B	XYZ Corporation	Common Stock
C	Smith Family Trust	Beneficiary
D	Planet Us Company	Stock in trust
E	All American Fund	Deferred Compensation Mutual Fund
F	Lifeplan 2030	Deferred Compensation Investment
G	123 Corporation	Stock in Investment Account
H	Popular Company	Stock in IRA
I	MegaGrowth Fund	Mutual Fund in 401(k) Account

QUICK INVESTMENT DISCLOSURE GUIDE

(Advisory Opinion No. 2011-01)

If I have more than $1,000 invested in a(n).....	Do I need to disclose this investment?	Do I need to list the individual holdings within this investment?
Mutual Fund	Yes	No
Stock	Yes	No
Bond	Yes	No
Brokerage Account	Yes	Yes
Managed Account	Yes	Yes
Trust (Beneficiary)	Yes	Yes
Investment Club Account	Yes	Yes
529 Plan	Yes	Yes
ESA	Yes	Yes
Public Retirement System Account (PERS, STRS, SERS, HPRS, or OPFPF)	No	No
Social Security	No	No

NOTE: You are **not required** to disclose:

A. Saving and checking accounts, certificates of deposit, and other deposits with financial institutions; or
B. Personal identifying information such as social security or investment account number.

QUESTION 9–OFFICES AND FIDUCIARY RELATIONSHIPS: For more information, check out FAQs on Fiduciary Interest

List the name of each corporation that is incorporated in, or holds a certificate of compliance to do business in, Ohio, and every trust, business trust, partnership, or association incorporated or authorized to do business in Ohio, or transacting business in Ohio:

A. In which you held an office in 2016; or
B. With which you had a fiduciary relationship in 2016.

A person has a "**fiduciary relationship**" with an entity if he or she has the authority to make decisions in the entity's interests.

EXAMPLES:

	Corporation, Trust, Business Trust, Partnership, or Association	Office or Nature of Relationship
A	Buckeye Friends Trust	Trustee
B	Smith & Jones Co., L.P.A.	Partner
C	Smith Cleaning Company	Member, Board of Directors

SKIP QUESTIONS 10 and 11 if you are only required to file as a:

- College or university trustee;
- City, school district, ESC, or sanitary district official or employee and serving in a position paid less than $16,000 a year; or
- Candidate for a city, school district, or ESC position paid less than $16,000 a year.

QUESTION 10—MEALS, FOOD, AND BEVERAGES: For more information, check out FAQs on Meals

List any source of payment for meals, food, or beverages valued at over $100 that was received in connection with your official duties by you or any other person for your use of benefit in 2016.

Include your public agency if it paid for more than $100 of meals, food, or beverages for you.

NOTE: Because of an exception in the law, you are **not required** to disclose anyone who provided meals, food, or beverages to you:

A. At a meeting where you participated in a panel, seminar, or speaking engagement; or
B. At a meeting or convention of a national or state organization to which any state agency, legislative agency, state institution of higher education, political subdivision, or office or agency thereof, pays membership dues.

QUESTION 11—TRAVEL EXPENSES: For more information, check out FAQs on Travel Expenses

List **both** the source and the amount of each individual payment of travel expenses, received in 2016, that was:

A. Received by you in connection with your official duties; or
B. Paid to any other person for your use or benefit in connection with your official duties.

Include your public agency if it paid for or reimbursed travel expenses for you.

You must list each payment or reimbursement separately. Travel expenses include parking fees, lodging, airline tickets, and mileage reimbursements.

NOTE: Because of an exception in the law, you are **not required** to disclose anyone who provided travel expenses to a meeting or convention of a national or state organization to which any state agency, legislative agency, state institution of higher education, political subdivision, or office or agency thereof, pays membership dues.

SKIP QUESTION 12 unless you are a:

- State elected official; or
- State Employee; or
- State board or commission member (except college or university trustee).

QUESTION 12—NON-DISPUTED INFORMATION:

ALL state employees, state officials, and state board and commission members (except college and university trustees) are REQUIRED to answer Question 12.

If you received a statement from a legislative agent, executive agency or retirement system lobbyist or the employer of such that identifies you as the recipient of expenditures made by that lobbyist or employer, and you do not dispute the information contained in the statement, attach a copy of the statement or list the non-disputed information below. If you dispute a legislative lobbying expenditure made in your name please contact the Office of the Legislative Inspector General at **614-728-5100**. To dispute an executive or retirement system expenditure made in your name, please contact the Ohio Ethics Commission.

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FINANCIAL DISCLOSURE STATEMENT INSTRUCTIONS

QUESTION 13—SIGNATURE:

Please note that by signing your financial disclosure statement:

- You swear or affirm that this statement and any additional attachments have been prepared or carefully reviewed by you, and constitute your complete, truthful, and correct disclosure of all required information, and that the address listed in the PERSONAL CONTACT INFORMATION on page 1 is your correct mailing address;
- You acknowledge and understand that, among other potential violations and penalties, knowingly filing a false statement is a criminal misdemeanor of the first degree, in violation of Sections 102.02(D) and 2921.13(A)(7) of the Ohio Revised Code punishable by a fine of not more than $1,000, imprisonment of not more than six months, or both;
- You acknowledge and understand that filing a false statement may be grounds for removal from public office or dismissal from public employment, pursuant to Sections 3.04 and 124.34 of the Ohio Revised Code; and
- You acknowledge that you served in 2016, or are serving in or a candidate for in 2017, the position indicated in the STATUS section on page 1 of the statement.

BEFORE SIGNING AND SENDING YOUR STATEMENT:

Please carefully review your disclosure statement to make sure that you have answered ALL questions, either by disclosing the information required or checking the appropriate box indicating that you have no information to disclose. Incomplete statements will be returned for completion.

If you are required to pay your filing fee, check the box indicating that the fee is enclosed. Otherwise, check the box indicating that the agency you serve is required to pay your filing fee.

Unless your agency is required to pay your filing fee, please also enclose a check or money order payable to "Ohio Ethics Commission." State departments, boards, commissions, colleges, and universities are required to pay the disclosure filing fees for officials and employees who are required to file disclosure statements for service with those state agencies.
(If you are unsure of whether your agency must pay your filing fee, please contact your agency or the Ethics Commission.)

Please do NOT staple your payment to the statement.

Please mail the completed and signed statement, along with the filing fee, to:

OHIO ETHICS COMMISSION
William Green Building
30 West Spring Street, L3
Columbus, Ohio 43215-2256

If you have any questions before signing this statement, please contact the Ohio Ethics Commission at (614) 466-7090 or visit the Commission's web site: ethics.ohio.gov

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OHIO ETHICS COMMISSION
POST FILING NOTIFICATION & REMINDERS

LEAVING YOUR POSITION OR OFFICE IN 2017?

If you have left, or will be leaving, your public position or office at any time during 2017, please read the following reminders to be sure you are aware of any further personal financial disclosure or any applicable post employment disclosure requirements you may have to meet as a result of your public service.

Reminder to all filers who leave their positions or offices in 2017:

The Ohio Ethics Commission would like to remind you that in addition to filing this calendar year 2016 statement, you will also be required to file a financial disclosure statement for calendar year 2017 by **Tuesday, May 15, 2018** (the year after you have left service). This applies if you served for any length of time in 2017, even if it was for just a single day, or in the case of elected or appointed officials, even if your term expired on January 1, 2017.

Reminder to any state elected officer or employee who leaves public service in 2017:

Ohio's Post Employment Disclosure Law

In addition to filing a financial disclosure statement in 2018 for your final calendar year of public service, Ohio law also requires every state elected officer or employee who filed a financial disclosure statement to disclose their subsequent place of employment to the Joint Legislative Ethics Committee (JLEC) for 24 months after leaving public service. This disclosure is commonly referred to as post employment disclosure (PED) and is part of Ohio's PED Law which can be found in R.C. 102.021.

Only those financial disclosure statement filers that are leaving state service need to complete a PED. The Initial PED Statement is to be completed by departing employees and submitted to the JLEC by their public agency **not later than an employee's last day of employment**.

PED is separate and distinct from any financial disclosure filing requirement. Filing a PED Statement does not replace any duty to file a personal financial disclosure statement for the former employee's or official's final calendar year of public service.

Please Note: PED does NOT apply to county, city, or other local level financial disclosure filers.

For more information regarding PED, for any specific questions regarding PED, or to obtain a PED Statement to complete please visit the JLEC web site at http://www.jlec-olig.state.oh.us or call the JLEC at **(614) 728-5100**.

MODEL PUBLIC RECORDS POLICY

MISSION STATEMENT

Openness leads to a better informed citizenry, which leads to better government and better public policy. Consistent with the premise that government at all levels exists first and foremost to serve the interests of the people, it is the mission and intent of [public office] to at all times fully comply with and abide by both the spirit and the letter of Ohio's Public Records Act.

DEFINING PUBLIC RECORDS

All records kept by **[public office]** are public unless they are exempt from disclosure under Ohio law. All public records must be organized and maintained in such a way that they can be made available for inspection and copying.

A record is defined to include the following: A document in any format – paper, electronic (including, but not limited to, business e-mail) – that is created, received by, or comes under the jurisdiction of **[public office]** that documents the organization, functions, policies, decisions, procedures, operations, or other activities of the office.

RESPONSE TIMEFRAME

Public records are to be available for inspection during regular business hours, with the exception of published holidays. Public records must be made available for inspection promptly. Copies of public records must be made available within a reasonable period of time. "Prompt" and "reasonable" take into account the volume of records requested; the proximity of the location where the records are stored; and the necessity for any legal review and redaction of the records requested.

It is the goal of **[public office]** that all requests for public records should be acknowledged in writing or, if possible, satisfied within **[X]** business days following the office's receipt of the request.

HANDLING REQUESTS

No specific language is required to make a request for public records. However, the requester must at least identify the records with sufficient clarity to allow the office to identify, retrieve, and review the records. If it is not clear what records are being sought, the office must contact the requester for clarification, and should assist the requester in revising the request by informing the requester of the manner in which the office keeps its public records.

The requester does not have to put a records request in writing, and does not have to provide his or her identity or the intended use of the requested public record. It is this office's general policy that this information is not to be requested. However, the law does permit the office to ask for a written request, the requestor's identity, and/or the intended use of the information requested, but only (1) if a written request or disclosure of identity or intended use would benefit the requestor by enhancing the office's ability to identify,

locate, or deliver the public records that have been requested; and (2) after telling the requestor that a written request is not required and that the requester may decline to reveal the requestor's identity or intended use.

In processing the request, the office does not have an obligation to create new records or perform new analysis of existing information. An electronic record is deemed to exist so long as a computer is already programmed to produce the record through simple sorting, filtering, or querying. Although not required by law, the office may accommodate the requestor by generating new records when it makes sense and is practical under the circumstances.

In processing a request for inspection of a public record, an office employee must accompany the requester during inspection to make certain original records are not taken or altered.

A copy of the most recent edition of the Ohio Sunshine Laws manual is available via the Attorney General's internet website (www.ohioattorneygeneral.gov) for the purpose of keeping employees of the office and the public educated as to the office's obligations under the Ohio Public Records Act, Open Meetings Act, records retention laws and Personal Information Systems Act.

ELECTRONIC RECORDS

Records in the form of e-mail, text messaging, and instant messaging, including those sent and received via a hand-held communications device (such as a Blackberry) are to be treated in the same fashion as records in other formats, such as paper or audiotape.

Public record content transmitted to or from private accounts or personal devices is subject to disclosure. All employees or representatives of this office are required to retain their e-mail records and other electronic records in accordance with applicable records retention schedules.

DENIAL OR REDACTION OF RECORDS

If the requester makes an ambiguous or overly broad request or has difficulty in making a request for public records, the request may be denied, but the denial must provide the requester an opportunity to revise the request by informing the requester of the manner in which records are maintained and accessed by the office.

Any denial of public records requested must include an explanation, including legal authority. If the initial request was made in writing, the explanation must also be in writing. If portions of a record are public and portions are exempt, the exempt portions may be redacted and the rest released. When making public records available for public inspection or copying, the office shall notify the requestor of any redaction or make the redaction plainly visible. If there are redactions, each redaction must be accompanied by a supporting explanation, including legal authority.

COPYING AND MAILING COSTS

Those seeking public records may be charged only the actual cost of making copies, not labor. The charge for paper copies is **[X]** cents per page. The charge for electronic files

downloaded to a compact disc is **[X]** per disc.

A requester may be required to pay in advance for costs involved in providing the copy. The requester may choose whether to have the record duplicated upon paper, upon the same medium in which the public record is kept, or upon any other medium on which the office determines that the record can reasonably be duplicated as an integral part of the office's normal operations.

If a requester asks that documents be mailed, he or she may be charged the actual cost of the postage and mailing supplies. There is no charge for documents e-mailed.

MANAGING RECORDS

[Public office] records are subject to records retention schedules. The office's current schedules are available at **[location]**, a location readily available to the public as required by §149.43(B)(2), Ohio Revised Code.

REQUEST TO REDACT ADDRESS

Pursuant to O.R.C. 149.45(D)(1), a peace officer, parole officer, probation officer, bailiff, prosecuting attorney, assistant prosecuting attorney, correctional employee, community-based correctional facility employee, youth services employee, firefighter, EMT or Bureau of Criminal Identification and Investigation investigator may file this form with a public office, other than a county auditor's office, to request that the address of the person making the request be redacted from any record made available by that office to the public on the internet.* ****For purposes of this law, "address" is defined as "actual personal residence" by O.R.C. 149.43(A)(7)(a).*** *This form is required to "include a place to provide any information that identifies the location of the address [of the individual] to be redacted." O.R.C. 149.45 (D)(4). If redaction is not practible, the public office shall, within five business days after receiving the written request, explain to the individual why the redaction is impractible. O.R. C. 149.45(D)(2)*

Instructions:

- **Complete entire form below and send directly to the public office that maintains the records to be redacted. Each individual requesting redaction is required to send the completed form to the appropriate public office. The Ohio Attorney General will not forward requests on behalf of the requesting individual.**
- The Ohio Attorney General is not required or permitted to review and/or approve a request for redaction.

I, _____ , request that the office of _____
(print full name) *(print full name of public office)*
redact the address of my actual personal residence from any record made available to the general public on the internet that includes my residential and familial information.

Requester is currently employed as a (Check only the ONE that applies):

☐ Peace Officer	☐ Assistant Prosecuting Attorney	☐ Firefighter	☐ Probation Officer
☐ BCI&I Investigator	☐ Correctional Employee	☐ EMT	☐ Bailiff
☐ Prosecuting Attorney	☐ Youth Services Employee	☐ Parole Officer	☐ Community-Based Correctional Facility Employee

(Use separate forms if Requester is currently employed and/or commissioned in more than one category.)

To verify employment or commission status, please provide:

Employer: _____

Employer Address/Contact Information: _____

For each known instance, please identify the location of your actual personal residential address within any record made available by this office to the public on the internet:

Document Title and Description:
Specific Web Address (URL):
Location Within Document of Address to be Redacted:

(Use the second page of this form to identify additional locations of address to be redacted)

Signature of Requester:_____ Date_____

If a requested redaction is impractible, we will provide you with an explanation within five (5) business days after receiving your written request. Please provide contact information below, or indicate that you will contact this office to receive an explanation.

Address: _____

Telephone Number: (____)_____ E-mail Address: _____

___I do not wish to provide contact information. I will contact the office for an explanation.

Date Request Received / / **(To be completed by the public office)**

****This document is a public record, and the information you provide may be released in response to a public records request.****

Document Title and Description:
Specific Web Address (URL):
Location Within Document of Address to be Redacted:

Document Title and Description:
Specific Web Address (URL):
Location Within Document of Address to be Redacted:

Document Title and Description:
Specific Web Address (URL):
Location Within Document of Address to be Redacted:

Document Title and Description:
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Document Title and Description:
Specific Web Address (URL):
Location Within Document of Address to be Redacted:

Document Title and Description:
Specific Web Address (URL):
Location Within Document of Address to be Redacted:

REQUEST TO REDACT PERSONAL INFORMATION

Under paragraph 149.45(C)(1) of the Ohio Revised Code, an individual may request that a public office or a person responsible for a public office's public records redact specified types of personal information of that individual from any record made available to the general public on the internet. An individual who makes a request for redaction "shall…provide any information that identifies the location of that personal information within a document that contains that personal information." O.R.C. 149.45(C)(1) If redaction is not practicable, the public officer or person responsible for the public office's public records shall verbally or in writing within five business days after receiving the written request explain to the individual why the redaction is impracticable. O.R.C. 149.45 (C) (3)

I, request that the
(Print full name)

Office of_____redact the following items of personal information from being made available to the public on the Internet:

(Please check all that apply)

____ Social security number
____ Checking account number
____ Tax identification number
____ Savings account number
____ Driver's license number
____ Credit card number

___ State identification number as issued by the Ohio Bureau of Motor Vehicles

For each item of personal information checked above, please identify the location of that information within any record made available by this office to the public on the internet:

Document Title and Description:
Specific Web Address (URL):
Location of information within document:

(Use the back of this form to identify additional locations of personal information items)

Signature of Requester:

_____

The public office may need to contact you:

1) To request additional information to locate your specific personal information to be redacted or to identify the appropriate public office responsible for redacting your personal information.

2) To provide you with an explanation within five (5) business days after receiving your written request, if a requested redaction is impracticable. Please provide contact information below, or indicate that you will contact this office to receive any explanation. This form is a public record, and the information you provide may be released in response to a public records request.

Address: _____

Telephone Number (_____) _____ Email Address: _____

_____I do not wish to provide contact information. I will contact the office for any explanation.

Date Request Received__/_____/_____(To be completed by the public office)

Document Title and Description:
Specific Web Address (URL):
Location of information within document:

Document Title and Description:
Specific Web Address (URL):
Location of information within document:

Document Title and Description:
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Document Title and Description:
Specific Web Address (URL):
Location of information within document:

Consent for Release of Information

Instructions for Using this Form

Complete this form only if you want us to give information or records about you, a minor, or a legally incompetent adult, to an individual or group (for example, a doctor or an insurance company). If you are the natural or adoptive parent or legal guardian, acting on behalf of a minor child, you may complete this form to release only the minor's non-medical records. We may charge a fee for providing information unrelated to the administration of a program under the Social Security Act.

NOTE: Do not use this form to:

- Request the release of medical records on behalf of a minor child. Instead, visit your local Social Security office or call our toll-free number, 1-800-772-1213 (TTY-1-800-325-0778), or
- Request detailed information about your earnings or employment history. Instead, complete and mail form SSA-7050-F4. You can obtain form SSA-7050-F4 from your local Social Security office or online at www.ssa.gov/online/ssa-7050.pdf.

How to Complete this Form

We will not honor this form unless all required fields are completed. An asterisk (*) indicates a required field. Also, we will not honor blanket requests for "any and all records" or the "entire file." You must specify the information you are requesting and you must sign and date this form. We may charge a fee to release information for non-program purposes.

- Fill in your name, date of birth, and social security number or the name, date of birth, and social security number of the person to whom the requested information pertains.
- Fill in the name and address of the person or organization where you want us to send the requested information.
- Specify the reason you want us to release the information.
- Check the box next to the type(s) of information you want us to release including the date ranges, where applicable.
- You, the parent or the legal guardian acting on behalf of a minor child or legally incompetent adult, must sign and date this form and provide a daytime phone number.
- If you are not the individual to whom the requested information pertains, state your relationship to that person. We may require proof of relationship.

PRIVACY ACT STATEMENT

Section 205(a) of the Social Security Act, as amended, authorizes us to collect the information requested on this form. We will use the information you provide to respond to your request for access to the records we maintain about you or to process your request to release your records to a third party. You do not have to provide the requested information. Your response is voluntary; however, we cannot honor your request to release information or records about you to another person or organization without your consent. We rarely use the information provided on this form for any purpose other than to respond to requests for SSA records information. However, the Privacy Act (5 U.S.C. § 552a(b)) permits us to disclose the information you provide on this form in accordance with approved routine uses, which include but are not limited to the following:

1.To enable an agency or third party to assist Social Security in establishing rights to Social Security benefits and or coverage;
2.To make determinations for eligibility in similar health and income maintenance programs at the Federal, State, and local level;
3.To comply with Federal laws requiring the disclosure of the information from our records; and,
4.To facilitate statistical research, audit, or investigative activities necessary to assure the integrity of SSA programs.

We may also use the information you provide when we match records by computer. Computer matching programs compare our records with those of other Federal, State, or local government agencies. We use information from these matching programs to establish or verify a person's eligibility for Federally-funded or administered benefit programs and for repayment of incorrect payments or overpayments under these programs. Additional information regarding this form, routine uses of information, and other Social Security programs is available on our Internet website, www.socialsecurity.gov, or at your local Social Security office.

PAPERWORK REDUCTION ACT STATEMENT

This information collection meets the requirements of 44 U.S.C. § 3507, as amended by section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take about 3 minutes to read the instructions, gather the facts, and answer the questions. **SEND OR BRING THE COMPLETED FORM TO YOUR LOCAL SOCIAL SECURITY OFFICE. You can find your local Social Security office through SSA's website at** www.socialsecurity.gov**. Offices are also listed under U.S. Government agencies in your telephone directory or you may call 1-800-772-1213 (TYY 1-800-325-0778).** You may send comments on our time estimate above to: SSA, 6401 Security Blvd., Baltimore, MD 21235-6401. ***Send only comments relating to our time estimate to this address, not the completed form.***

Social Security Administration

Consent for Release of Information

You must complete all required fields. We will not honor your request unless all required fields are completed. *(*signifies a required field).*

1. ☐

TO: Social Security Administration

_____ _____

***My Full Name *My Date of Birth (MM/DD/YYYY)** ***My Social Security Number**

I authorize the Social Security Administration to release information or records about me to:

***NAME OF PERSON OR ORGANIZATION:** ***ADDRESS OF PERSON OR ORGANIZATION:**

_____ _____

_____ _____

***I want this information released because:**

We may charge a fee to release information for non-program purposes.

_____

_____

***Please release the following information selected from the list below:**

You must specify the records you are requesting by checking at least one box. We will not honor a request for "any and all records" or "my entire file." Also, we will not disclose records unless you include the applicable date ranges where requested.

Social Security Number

2. ☐ Current monthly Social Security benefit amount
3. ☐ Current monthly Supplemental Security Income payment amount
4. ☐ My benefit or payment amounts from date _____ to date _____
5. ☐ My Medicare entitlement from date _____ to date _____
6. ☐ Medical records from my claims folder(s) from date _____ to date_____

If you want us to release a minor child's medical records, do not use this form. Instead, contact your local Social Security office.

7. ☐ Complete medical records from my claims folder(s).
8. ☐ Other records from my file **(you must specify the records you are requesting, e.g. doctor report, application, determination or questionnaire).**

_____

_____

I am the individual, to whom the requested information or record applies, or the parent or legal guardian of a minor, or the legal guardian of a legally incompetent adult. I declare under penalty of perjury (28 CFR § 16.41(d)(2004)) that I have examined all the information on this form, and any accompanying statements or forms, and it is true and correct to the best of my knowledge. I understand that anyone who knowingly or willfully seeks or obtain access to records about another person under false pretenses is punishable by a fine of up to $5,000. I also understand that I must pay all applicable fees for requesting information for a non-program-related purpose.

***Signature:** _____ ***Date:** _____

***Address:** _____

Relationship (if not the subject of the record): _____ ***Daytime Phone:** _____

Witnesses must sign this form ONLY if the above signature is by mark (X). If signed by mark (X), two witnesses to the signing who know the signee must sign below and provide their full addresses. Please print the signee's name next to the mark (X) on the signature line above.

1.Signature of witness	2.Signature of witness
Address(Number and street,City,State, and Zip Code)	Address(Number and street,City,State, and Zip Code)

Form SSA-3288 (07-2013) EF (07-2013)

Section IV

Hiring

Application for Employment

Return to: _____

Equal access to programs, services and employment is available to all persons. Those applicant requiring accommodation to the application and/or interview process should notify the Human Resources Department. We consider all applicants for all positions without regard to race, color, religion, creed, gender, national origin, age, disability, marital or veteran status, or any other legally protected status.

Position(s) applied for: _____

Date of Application: _____

How did you hear about the position?

Advertisement: ___ Relative: ___ Inquiry: ___ Website: ___ Friend: ___

Employment Agency___ Other: _____

Name : _____
Last First Middle

Mailing Address:_____
Street Apt. City State Zip

Telephone #: (_____)_____ Mobile/Other: (_____) _____

E-mail: _____ Best time to contact you at home is: ____am / pm

Have you ever submitted an application to (County Name)? _____ If Yes, when?_____

Have you ever been employed by (County Name)? _____ If Yes, when?_____

Are you legally eligible for employment in the United States?_____

If you are under 18, can you furnish a work permit? _____

Do you have a valid driver's license? _____ State / Number: _____

Are you able to meet all of the attendance requirements of this position? _____

Are you able to work overtime if necessary? _____ Will you travel if the position requires it? _____

Do you have any friends / relatives currently employed by_____County?_____

If Yes, who?
_____

What is your desired salary range or rate of pay: $ _____ per _____

Date available for work: _____

Type of employment desired: □ Full Time □ Part Time □ Seasonal

Employment History: Starting with your most recent employer, provide the following information. Include any relevant volunteer activities, but exclude any organizations that would reveal race, color, religion, sex, national origin, citizenship, age, mental or physical disabilities, veteran/reserve National Guard or any other similarly protected status.

1. From/To_____ Employer/Organization_____

Telephone # _____ Address_____

Job Title:_____ Supervisor_____ May We Contact?_____

Job Duties/Responsibilties_____

Reason for Leaving_____ Final Rate of Pay: _____

2. From/To_____ Employer/Organization_____

Telephone # _____ Address_____

Job Title:_____ Supervisor_____ May We Contact?_____

Job Duties/Responsibilties_____

Reason for Leaving_____ Final Rate of Pay: _____

3. From/To_____ Employer/Organization_____

Telephone # _____ Address_____

Job Title:_____ Supervisor_____ May We Contact?_____

Job Duties/Responsibilties_____

Reason for Leaving_____ Final Rate of Pay: _____

4. From/To_____ Employer/Organization_____

Telephone # _____ Address_____

Job Title:_____ Supervisor_____ May We Contact?_____

Job Duties/Responsibilties_____

Reason for Leaving_____ Final Rate of Pay: _____

Please Explain Any Gaps In Employment:

_____

_____

Have you ever been fired or asked to resign from a job? _____

If yes, please explain

_____

_____

_____

EDUCATION

	Name and Address of School	Course of Study	Years Completed	Diploma/Degree Obtained
High School				
Undergraduate College				
Graduate Professional				
Other (specify)				

Related Information: Please list any relevant professional or trade organizations of which you are a member. Exclude memberships that would reveal race, color, religion, sex, national origin, citizenship, age, mental or physical disabilities, veteran/reserve National Guard or any other similarly protected status.

Organization	Offices Held

Please discuss your interest in employment with _____ County and any qualifications beyond what is reflected in your application. Use additional sheets if needed.

_____

_____

_____

_____

_____

References: Please provide the names and telephone numbers of three professional references who are not related to you and are not previous supervisors. If professional references are not available, provide school or personal references who are not related to you.

Name: _____ Title: _____
Relationship: _____ Telephone: _____
Email: _____

Name: _____ Title: _____
Relationship: _____ Telephone: _____
Email: _____

Name: _____ Title: _____
Relationship: _____ Telephone: _____
Email: _____

Applicant Statement and Signature:

I certify that all information I have provided in order to apply for and obtain employment with _____ County is true, complete, and correct. I agree and understand that omissions, misstatements, and falsifications will cause forfeiture on my part of all eligibility to any employment with _____ County and may be cause for rejection of this application, removal of my name from eligibility lists, or discharge from County service, whenever it is discovered. I give _____ County the right to investigate and verify any information obtained through the application process. Permission is granted and I release from any and all liability any employer, agency or individual assisting _____ County in providing relevant, job-related information that will assist in this process. I expressly authorize, without reservation, _____ County, its representatives, members or agents to contact and obtain information from all references (personal and professional), employers, public agencies, licensing authorities and educational institutions and to otherwise verify the accuracy of all information provided by me in this application. I hereby waive any and all rights and claims I may have regarding _____ County, its agents, members or representatives, for seeking, gathering, and using such information and all other persons, corporations, or organizations for furnishing such information about me.

I understand that an offer of employment may be contingent upon the successful completion of a pre-employment background criminal investigation, physical, psychological, polygraph, and/or drug and alcohol screen. If employed, I agree to provide proof of identity, relevant licensure or credentials, and authorization for employment in the United States. If I am hired, I understand that, unless otherwise defined by applicable law, any employment relationship with _____ County is of an "*at will*" nature, which means that I am free to resign at any time and _____ County reserves the same right to terminate my employment at any time. This application does not constitute an agreement or contract for employment for any specified period or definite duration. I understand that all conditions of employment including, but not limited to hours, benefits and salary are subject to change by _____ County at any time. I understand that no representative of _____ County is authorized to make any assurances to the contrary and that no implied, oral or written agreements contrary to the foregoing express language are valid unless they are in writing and signed by the appropriate Appointing Authority.

DO NOT SIGN UNTIL YOU READ THE ABOVE APPLICANT STATEMENT.
I certify that I have read, fully understand, and accept all terms of the foregoing Applicant Statement.

Applicant Signature: _____ Date: ____/_____/_____

CONSENT TO CONDUCT BACKGROUND INVESTIGATION AND RELEASE

I_____hereby permit_____to conduct a background investigation, including my criminal history, concerning matters related to my application for employment. As a result of this background investigation I understand that_____ will be seeking

information from prior employers and other individuals, including various law enforcement agencies, that I may or may not have disclosed. By signing this release, I hereby consent all prior employers, law enforcement agencies and educational institutions to provide necessary information to this employer during the background investigation. I hereby release, hold harmless and agree not to sue or file any claim of any kind against any current or former employer, law enforcement agency or educational institution, and any officer or employee of either, that in good-faith furnishes written or oral references as requested by this employer to complete its background investigation.

A photocopy or facsimile of this form that shows my signature is valid as an original.

Dated this _____ day of _____, 20___

_____ _____

Witness Applicant

MIKE DEWINE
OHIO ATTORNEY GENERAL

Civilian Identification
Office 877-224-0043
Fax 740-845-2633

P.O. Box 365
London, OH 43140
www.OhioAttorneyGeneral.gov

REQUEST FOR COPY OF BACKGROUND CHECK PROCEDURE

A request for a copy of a background check may only be submitted if the original background check was processed for working with children, working with the elderly, or certain types of licensing. If you are unsure if you are able to request a copy, please contact the Civilian Identification Dept. toll free at 877-224-0043 for further information.

You may only request a copy of the Ohio BCI background check. The FBI result is not permitted to be sent to any address other than what was requested at the time of the original background check. To obtain a new FBI result, a new FBI background check would have to be submitted.

A request for a copy of a background check must include the reason for processing of the original background check, as well as the individual's name, social security number, date of birth, address to send the result and the individual's signature.

The new background check result is valid for one year from the date of the original fingerprint submission.

If the request for copy is made within 30 days of the original background check there is no fee for processing and the request can be faxed to 740-845-2633. If the request for copy is made more than 30 days after the original background check the fee is $8 and is payable by money order, certified check, business check or personal check to Treasurer, State of Ohio. **No cash will be accepted.** The request and payment can be mailed to: BCI, PO Box 365, London Oh 43140.

Civilian Unit
Identification Department
Bureau of Criminal Identification & Investigation

Revised 3-30-12

MIKE DEWINE
OHIO ATTORNEY GENERAL

Civilian Identification Office
877-224-0043
Fax 740-845-2633

P.O. Box 365 London, OH
43140
www.OhioAttorneyGeneral.gov

BCI CIVILIAN BACKGROUND CHECK PROCEDURES

- Use only the BCI Civilian Background Check card for the State of Ohio background check. A release from submission of electronic fingerprint form must be completed and submitted with the card.

- The fee for a BCI check is $22.00. A money order, certified check, business check or personal check made payable to: Treasurer, State of Ohio, must accompany the card if you do not have a billable agency code established with BCI. Cash or starter checks will not be accepted.

- If payment is being submitted with a card, 1AB002 must be written in the Agency Code box and the address the result is to be sent to must be written in the Send Background Check Results To box. If the card is being billed to an agency code, write the agency code in the Agency Code box and the result will be returned to the address for the agency code.

- Each fingerprint card must be completed with required information (i.e., social security number, date of birth, etc.) this information may be validated with a driver's license or other photo I.D. All information should be typed or printed legibly.

- When taking fingerprints only fingerprinting ink should be used, and fingers should be rolled nail to nail.

- The Reason Fingerprinted field must be completed. Please check the appropriate box and specify the proper Ohio Revised Code section number that pertains to the reason fingerprinted if the box you check requires an Ohio Revised Code.

- If any of the aforementioned information is incomplete, fingerprint cards will be returned unprocessed. For questions regarding BCI civilian background checks, please call the Civilian Unit of BCI at 877-224-0043. Your cooperation is greatly appreciated.

Civilian Unit
Identification Department
Bureau of Identification & Investigation

Revised 09/05/13

APPENDIX E: BCI REASON FINGERPRINT CODES

This table lists each BCI Reason Fingerprint Code. Additional codes will be added as state legislation is authorized. The Code Number must be submitted to BCI&I in field 2.905 with appropriate spacing as listed below.

Reason Code	Reason Description
109 578	Prospective Firefighter / EMT Applicants
113 041	Ohio Treasurer of State employees
121 08	Ohio Department of Commerce
173 27	State long-term care ombudsperson program
173 38	Community based long term care agency
2151 86	Out of Home Child Care, Foster Parents, Adoptive Parents and all individuals 18 and over residing in home
311 41	Carry Concealed Weapons
311 41R	Carry Concealed Weapons – Renewal
311 41T	Carry Concealed Weapons – Temporary
311 41F	Carry Concealed Weapons – Retired LE
1121 23	Management of a bank
1155 03	Management of a savings and loan association
1163 05	Management of a savings bank
1315 141	Management of a licensee for a financial institution
1321 37	License to make short-term loans
1321 53	Certification of registration for a financial institution
1321 531	Application for a mortgage loan originator license
1322 03	Certification of registration as a mortgage broker
1322 031	License as a loan officer
1733 47	Management of a credit union
1761 26	Management of a credit union share guaranty corporation
2151 33	Temporary care of a juvenile
2151 412	Parent, guardian, custodian, prospective custodian, or prospective placement involved in a case plan
3301 32	Headstart Agency
3301 541	Preschool Program
3319 39B1	School Employees – non teaching positions
3319 39B3	School Employees – teachers only
3327 10	School Bus Driver
3701 881	Home Health Agency Responsible for Children or Adults (in-home patient care)
3712 09	Hospice Care Program
3721 121	Home or Adult Daycare Program

3734 42	Hazardous Waste Environmental Background Investigations
3769 03	Ohio Racing Commission
3770 02	Ohio Lottery Commission
3772 07	Ohio Casino Control Commission
3905 051	Applicant to obtain license to sell Insurance through the Ohio Dept of Insurance
4123 444	Investment managers/employees who contract with Ohio BWC to invest BWC funds
4303 29	Ohio Division of Liquor Control
4701 08	Accountancy Board license applicants
4715 101	State Dental Board license applicants
4717 061	Board of Embalmers and Funeral Directors license applicants
4723 09	Nurses (RNs, LPNs, dialysis techs, students entering nursing education or dialysis)
4725 121	State Board of Optometry license applicants
4725 501	Ohio Optical Dispensers Board license applicants
4729 071	State Board of Pharmacy license applicants
4729 42	Pharmacy Technician
4730 101	Physicians Assistant Certificate Applicants
4730 14	Renew a Certificate to Practice as a Physician Assistant
4730 28	Reinstatement of a Certificate to Practice as a Physician Assistant
4731 081	State Medical Board (practice medicine and surgery or osteopathic medicine or surgery)
4731 15	Certificate to practice massage therapy and cosmetic therapy
4731 171	Massage or Cosmetic Therapists certificate applicants
4731 222	Application for restoration of a medical certificate
4731 281	Renew a License to Practice Medicine
4731 296	Telemedicine practitioners certificate applicants
4731 531	Podiatrists (including surgeons) certificate applicants
4732 091	State Board of Psychology license applicants
4734 202	State Chiropractic Board license applicants
4740 061	Ohio Construction Industry license applicants
4741 10	Veterinary Medical Board license applicants
4749 03	License for Private Investigator or Security Guard
4749 06	Employment as Private Investigators/Security Guards
4755 70	Ohio Occupational Therapy, Physical Therapy, and Athletic Trainers Board license applicants
4757 101	Counselor, Social Worker, and Marriage and Family Therapists Board license applicants
4759 061	Ohio Board of Dietetics license applicants
4760 032	Anesthesiologist Assistant certificate of registration applicants
4760 06	Renewal or Reinstatement of a license to be an Anesthesiologist Assistant
4761 051	Ohio Respiratory Care Board license applicants
4762 031	Acupuncturist certificate of registration applicants
4762 06	Renew a license to practice Acupuncture

4763 05	License or Certificate for General Real Estate Appraisers, Residential Real Estate Appraisers, or Assistant
4776 02	Pain Management Clinic Owner/Employee
4776 021	Trainee license for any approved board
4779 091	State Board of Orthotics, Prosthetics, and Pedorthics license applicants
4783 04	Applicant for a certificate to practice as a certified Ohio behavior analyst
5104 012	Employees of Child Daycare Center Type A Family Daycare, Type B Family Daycare, Certified in Home Aide
5104 013	Child Daycare Center Owner, Licensees, or Administrator Type A Daycare Home owner and any person 18 yrs or older who resides in home
5164 34	Applicant for Medicaid provider
5164 342	Applicant with agency that provides home and community based waiver services
5164 341	Independent provider for the DJFS for home and community based waiver services
5123 081	Employment with DoDD, county board of DD or contracting agency
5123 169	Applicant for a supported living certificate
5153 111	Co. Public Children Services Board of Co. Human Services Administering child Welfare
LAW	Law Enforcement/Criminal Justice
PL104 120	Public Housing
NO ORC	Other: Please type specific reason

SAMPLE PRE-EMPLOYMENT DRUG TESTING CONSENT FORM

I understand that any offer of employment which may be made to me by the [PUBLIC ENTITY] is contingent upon my successfully passing a Drug Screening Test. I hereby give my consent to [PUBLIC ENTITY] to conduct a drug test that will be performed by a laboratory selected by [PUBLIC ENTITY], and which will provide for split sample testing. I also understand and agree that if the pre-employment Drug Screening Test indicates a violation of the Drug Testing Policy, any contingent job offer which may be or has been made to me will be null and void.

I further agree that in the event that the pre-employment Drug Screening Test indicates a violation of the Drug Testing Policy, I will have an opportunity to challenge this violation before [PUBLIC ENTITY HUMAN RESOURCES DEPARTMENT and/or appropriate department] by submitting a written request to the [APPROPRIATE DEPARTMENT] to review the record. I may submit additional written information that I believe to be appropriate to the [PUBLIC ENTITY] for consideration. Additionally, I may, at my cost, have the split sample referenced above tested to ensure the accuracy of the testing procedure. I understand that the decision of the [PUBLIC ENTITY HUMAN RESOURCES DEPARTMENT and/or appropriate department] shall be final.

Signature of Applicant _____ Date _____

Equal Employment Opportunity is

THE LAW

Private Employers, State and Local Governments, Educational Institutions, Employment Agencies and Labor Organizations

Applicants to and employees of most private employers, state and local governments, educational institutions, employment agencies and labor organizations are protected under Federal law from discrimination on the following bases:

RACE, COLOR, RELIGION, SEX, NATIONAL ORIGIN

Title VII of the Civil Rights Act of 1964, as amended, protects applicants and employees from discrimination in hiring, promotion, discharge, pay, fringe benefits, job training, classification, referral, and other aspects of employment, on the basis of race, color, religion, sex (including pregnancy), or national origin. Religious discrimination includes failing to reasonably accommodate an employee's religious practices where the accommodation does not impose undue hardship.

DISABILITY

Title I and Title V of the Americans with Disabilities Act of 1990, as amended, protect qualified individuals from discrimination on the basis of disability in hiring, promotion, discharge, pay, fringe benefits, job training, classification, referral, and other aspects of employment. Disability discrimination includes not making reasonable accommodation to the known physical or mental limitations of an otherwise qualified individual with a disability who is an applicant or employee, barring undue hardship.

AGE

The Age Discrimination in Employment Act of 1967, as amended, protects applicants and employees 40 years of age or older from discrimination based on age in hiring, promotion, discharge, pay, fringe benefits, job training, classification, referral, and other aspects of employment.

SEX (WAGES)

In addition to sex discrimination prohibited by Title VII of the Civil Rights Act, as amended, the Equal Pay Act of 1963, as amended, prohibits sex discrimination in the payment of wages to women and men performing substantially equal work, in jobs that require equal skill, effort, and responsibility, under similar working conditions, in the same establishment.

GENETICS

Title II of the Genetic Information Nondiscrimination Act of 2008 protects applicants and employees from discrimination based on genetic information in hiring, promotion, discharge, pay, fringe benefits, job training, classification, referral, and other aspects of employment. GINA also restricts employers' acquisition of genetic information and strictly limits disclosure of genetic information. Genetic information includes information about genetic tests of applicants, employees, or their family members; the manifestation of diseases or disorders in family members (family medical history); and requests for or receipt of genetic services by applicants, employees, or their family members.

RETALIATION

All of these Federal laws prohibit covered entities from retaliating against a person who files a charge of discrimination, participates in a discrimination proceeding, or otherwise opposes an unlawful employment practice.

WHAT TO DO IF YOU BELIEVE DISCRIMINATION HAS OCCURRED

There are strict time limits for filing charges of employment discrimination. To preserve the ability of EEOC to act on your behalf and to protect your right to file a private lawsuit, should you ultimately need to, you should contact EEOC promptly when discrimination is suspected: The U.S. Equal Employment Opportunity Commission (EEOC), 1-800-669-4000 (toll-free) or 1-800-669-6820 (toll-free TTY number for individuals with hearing impairments). EEOC field office information is available at www.eeoc.gov or in most telephone directories in the U.S. Government or Federal Government section. Additional information about EEOC, including information about charge filing, is available at www.eeoc.gov.

Employers Holding Federal Contracts or Subcontracts

Applicants to and employees of companies with a Federal government contract or subcontract are protected under Federal law from discrimination on the following bases:

RACE, COLOR, RELIGION, SEX, NATIONAL ORIGIN

Executive Order 11246, as amended, prohibits job discrimination on the basis of race, color, religion, sex or national origin, and requires affirmative action to ensure equality of opportunity in all aspects of employment.

INDIVIDUALS WITH DISABILITIES

Section 503 of the Rehabilitation Act of 1973, as amended, protects qualified individuals from discrimination on the basis of disability in hiring, promotion, discharge, pay, fringe benefits, job training, classification, referral, and other aspects of employment. Disability discrimination includes not making reasonable accommodation to the known physical or mental limitations of an otherwise qualified individual with a disability who is an applicant or employee, barring undue hardship. Section 503 also requires that Federal contractors take affirmative action to employ and advance in employment qualified individuals with disabilities at all levels of employment, including the executive level.

DISABLED, RECENTLY SEPARATED, OTHER PROTECTED, AND ARMED FORCES SERVICE MEDAL VETERANS

The Vietnam Era Veterans' Readjustment Assistance Act of 1974, as amended, 38 U.S.C. 4212, prohibits job discrimination and requires affirmative action to employ and advance in employment disabled veterans, recently separated veterans (within three years of discharge or release from active duty), other protected veterans (veterans who served during a war or in a campaign or expedition for which a campaign badge has been authorized), and Armed Forces service medal veterans (veterans who, while on active duty, participated in a U.S. military operation for which an Armed Forces service medal was awarded).

RETALIATION

Retaliation is prohibited against a person who files a complaint of discrimination, participates in an OFCCP proceeding, or otherwise opposes discrimination under these Federal laws.

Any person who believes a contractor has violated its nondiscrimination or affirmative action obligations under the authorities above should contact immediately:

The Office of Federal Contract Compliance Programs (OFCCP), U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210, 1-800-397-6251 (toll-free) or (202) 693-1337 (TTY). OFCCP may also be contacted by e-mail at OFCCP-Public@dol.gov, or by calling an OFCCP regional or district office, listed in most telephone directories under U.S. Government, Department of Labor.

Programs or Activities Receiving Federal Financial Assistance

RACE, COLOR, NATIONAL ORIGIN, SEX

In addition to the protections of Title VII of the Civil Rights Act of 1964, as amended, Title VI of the Civil Rights Act of 1964, as amended, prohibits discrimination on the basis of race, color or national origin in programs or activities receiving Federal financial assistance. Employment discrimination is covered by Title VI if the primary objective of the financial assistance is provision of employment, or where employment discrimination causes or may cause discrimination in providing services under such programs. Title IX of the Education Amendments of 1972 prohibits employment discrimination on the basis of sex in educational programs or activities which receive Federal financial assistance.

INDIVIDUALS WITH DISABILITIES

Section 504 of the Rehabilitation Act of 1973, as amended, prohibits employment discrimination on the basis of disability in any program or activity which receives Federal financial assistance. Discrimination is prohibited in all aspects of employment against persons with disabilities who, with or without reasonable accommodation, can perform the essential functions of the job.

If you believe you have been discriminated against in a program of any institution which receives Federal financial assistance, you should immediately contact the Federal agency providing such assistance.

EEOC 9/02 and OFCCP 8/08 Versions Useable With 11/09 Supplement EEOC-P/E-1 (Revised 11/09)

Section V

Medical-ADA-FMLA-WC

ADA Best Practices Tool Kit for State and Local Governments

Chapter 2 Addendum:

Title II Checklist

(ADA Coordinator, Notice & Grievance Procedure)

PURPOSE OF THIS CHECKLIST: This checklist is designed for use as an assessment of **(1) the requirements and tasks of an ADA Coordinator, (2) the government entity's provision of the ADA notice, and (3) the government entity's ADA grievance procedures.**

MATERIALS AND INFORMATION NEEDED: To assess compliance with these administrative requirements, you will need:

- ✓ a copy of the written position description for an ADA Coordinator, if applicable;
- ✓ information about the procedures followed by the ADA Coordinator to ensure compliance with the ADA, how complaints are processed, and other tasks performed by the ADA Coordinator;
- ✓ a copy of the written notice or notices used by the state or local government; and
- ✓ a copy of the written grievance procedures used by the state or local government.

ADA Coordinator

1. Does the state or local government have an ADA Coordinator? All state and local governments with 50 or more employees are required to designate at least one responsible employee to coordinate ADA compliance.

- ☐ Yes, the state or local government has an ADA Coordinator.
- ☐ No, the state or local government does not have an ADA Coordinator but an ADA Coordinator is not required because the public entity has fewer than 50 employees, including all part-time and full-time employees.
- ☐ No, the state or local government does not have an ADA Coordinator even though it has 50 or more employees.

ACTIONS:

If the local government has fewer than 50 employees, it is not required to have an ADA coordinator. HOWEVER, it is strongly recommended that an ADA coordinator be appointed.

If the state or local government has 50 or more employees, it must have a designated ADA Coordinator. Any state or local government that does not have an ADA coordinator is in violation of federal law. An ADA Coordinator must be designated.

2. Does the ADA Coordinator have the time and expertise necessary to coordinate the government's efforts to comply with and carry out its responsibilities under the ADA?

- ☐ Yes
- ☐ No

3. Does the ADA coordinator actually carry out these duties?

- ☐ Yes
- ☐ No

4. Does the ADA Coordinator investigate all complaints communicated to the government alleging that the government does not comply with the ADA?

- ☐ Yes
- ☐ No

5. Does the government make available to all interested people the name, office address, and telephone number of the ADA Coordinator?

- ☐ Yes
- ☐ No

ACTIONS:

If you checked "no" for any of the questions above, here are some steps you can take to improve the coordination of your ADA compliance:

- ✓ Ensure that the ADA Coordinator has the time and expertise necessary to coordinate the government's efforts to comply with and carry out its responsibilities under the ADA.
- ✓ Ensure that the ADA Coordinator actually carries out these duties.
- ✓ Ensure that the ADA Coordinator investigates all complaints communicated to the government alleging that the government does not comply with the ADA.
- ✓ Make available to all interested people the name, office address, and telephone number of the ADA coordinator.

Notice

1. Does the state or local government make information available to the general public regarding the fact that the ADA applies to the services, programs, and activities of the government?

☐ Yes
☐ No

2. Does the state or local government use the Department of Justice's model "Notice Under the Americans with Disabilities Act" or a similarly comprehensive notice?

☐ Yes
☐ No

3. Does the state or local government post this information in public areas or make it available in other ways as deemed necessary by the head of the government entity to inform people of the protections of the ADA?

☐ Yes
☐ No

4. Is the ADA notice available in alternate formats – i.e., large print, Braille, audio format, accessible electronic format (e.g., via email, in HTML format on its website)?

☐ Yes
☐ No

ACTIONS:

If you checked "no" for any of the questions above, your office may be violating the requirement for providing notice.

- ✓ Make information available to all interested members of the general public regarding the prohibition of discrimination against people with disabilities.
- ✓ Consider using the Department of Justice's model "Notice Under the Americans with Disabilities Act," or use a similarly comprehensive notice.
- ✓ Make this information available by posting it in common areas of public buildings, posting it on the government's website, or otherwise disseminating it as necessary to inform the public of the ADA's protections.
- ✓ Make the ADA notice available in alternate formats.

Grievance Procedures

1. Does the state or local government have a grievance procedure? All state and local governments with 50 or more employees are required to adopt and publish grievance procedures providing for prompt and fair resolution of complaints of discrimination on the basis of disability.

- ☐ Yes, the state or local government has a grievance procedure.
- ☐ No, the state or local government has fewer than 50 employees, including all part-time and full-time employees, and is not required to have a grievance procedure.
- ☐ No, the state or local government does not have a grievance procedure even though it has 50 or more employees.

2. Does the local government use the Department of Justice's model "Grievance Procedure under the Americans with Disabilities Act" or a similarly comprehensive grievance procedure (i.e., a grievance procedure for complaints made by any member of the public under the ADA related to any program, service, or activity)?

- ☐ Yes
- ☐ No
- ☐ No, Not applicable, no grievance procedure is required because the public entity has fewer than 50 employees.

3. Is the grievance procedure available in alternate formats?

- ☐ Yes
- ☐ No

ACTIONS:

If the local government has fewer than 50 employees, it is not required to have a grievance procedure. HOWEVER, it is strongly recommended that a grievance procedure be adopted and published by all localities subject to title II of the ADA.

If the state or local government has 50 or more employees, it must have a published grievance procedure. Any state or local government that does not have a grievance procedure is in violation of federal law. A grievance procedure must be adopted and published.

- ✓ Consider using the Department of Justice's model "Grievance Procedure under the Americans with Disabilities Act," or use a similarly comprehensive grievance procedure.
- ✓ Provide copies of your procedure in alternate formats upon request.

Chapter 2 Addendum: Title II Checklist
(ADA Coordinator, Notice & Grievance Procedure
(December 5, 2006)

ADA Best Practices Tool Kit for State and Local Governments

Chapter 7 Addendum 1:

Title II Checklist (Emergency Management)

PURPOSE OF THIS CHECKLIST: This checklist is designed for use as a preliminary assessment of your emergency management programs, policies, procedures, and shelter facilities. The goal is to look at your programs, policies, procedures, and shelter facilities to see if there are any potential ADA problems.

MATERIALS AND INFORMATION NEEDED: To assess the accessibility of your emergency management programs, policies, procedures, and shelter facilities, you will need:

- ✓ a copy of your emergency planning and preparedness documents;
- ✓ a copy of materials used to train employees and volunteers who perform emergency management functions;
- ✓ a copy of materials distributed to the public on emergency preparedness and emergency management and the procedures used for distribution of such materials;
- ✓ a copy of any current contracts or other documents reflecting your relationship with other public entities and/or private organizations to provide any services related to emergency management, such as planning, prevention, preparedness, evacuation, transportation, sheltering, medical services, lodging, housing, response, social services, recovery, clean-up, and remediation;
- ✓ a list of notification methods, procedures, materials, and equipment used to communicate information about emergencies to the public, including people with disabilities (in particular, communication with people who are deaf or hard of hearing and people who are blind or have low vision);
- ✓ a copy of your policies and procedures on emergency notification, evacuation, transportation, emergency shelters, emergency food and medical supplies, temporary lodging and housing, medical services, social services, and other emergency management services;
- ✓ a list of accessible transportation and lodging resources that can be used in an emergency for evacuation, return home following an evacuation, and/or temporary lodging and housing;
- ✓ a list of the facilities designated as emergency shelters, including mass care shelters, special needs shelters, and medical shelters;
- ✓ eligibility criteria, if any, for participation in emergency management programs, services, and activities, including mass care, special needs, and medical shelters; and

- ✓ copies of the "ADA Checklist for Emergency Shelters," located in Addendum 3 to this Chapter and at , and survey tools (metal tape measure, electronic (digital) level, pressure gauge, and digital camera).

General Emergency Management Policies and Procedures

1. If you have a contract or other arrangement with any third party entities, such as the American Red Cross or another local government, to provide emergency planning and/or emergency management or response services, does your contract or other documentation of your arrangement contain policies and procedures to ensure that the third party entities comply with ADA requirements, as outlined in Chapter 7 of this Tool Kit, including Addenda 2 and 3?

- ☐ Yes
- ☐ No
- ☐ N/A

2. Do you have written procedures to ensure that you regularly seek and use input from persons with a variety of disabilities and organizations with expertise in disability issues in all phases of your emergency planning, such as those addressing preparation, notification, evacuation, transportation, sheltering, medical and social services, temporary lodging and/or housing, clean-up, and remediation?

- ☐ Yes
- ☐ No

3. Do you seek input and participation from people with disabilities and organizations with expertise on disability issues when you stage emergency simulations and otherwise test your preparedness?

- ☐ Yes
- ☐ No

ACTIONS:

If the answer to any of the above questions is "No," this is a red flag that your emergency management program may not be fully accessible to people with disabilities. Here are some steps to ensure that your emergency management programs, policies, and procedures are accessible to people with disabilities.

- ✓ If your entity contracts or arranges with third party organizations to help with emergency preparedness or management, formalize in your agreements with those organizations their commitment to compliance with the requirements of Title II of the ADA, as set out in this Chapter, including the Addenda.
- ✓ On an ongoing basis, seek and use input from people with different types of disabilities (i.e., mobility, vision, hearing, cognitive, psychiatric, and other disabilities) and organizations with expertise on disability issues regarding all phases of your emergency management plan.
- ✓ When you stage simulations or otherwise test the effectiveness of your emergency planning and preparedness, include people with a variety of disabilities in your testing. For example, enlist people with disabilities to role-play during simulation exercises and provide feedback.

Planning for Emergency Notification and Evacuation

This section helps you identify potential ADA-related problems in your plans for the emergency notification and evacuation of people with disabilities. To ensure an accurate assessment of ADA compliance, this checklist should be completed with the input and assistance of those employees and contractors who are involved in your entity's emergency planning, notification, and evacuation programs, services, and activities.

4. For planning purposes, have you determined the extent to which, in an emergency or disaster, people with disabilities who reside or visit your community are likely to need individualized notification, evacuation assistance, and/or transportation, including accessible transportation?

☐ Yes
☐ No

5. Has your emergency planning identified the resources you will use to meet the needs of individuals with disabilities who require individualized notification, evacuation assistance, and/or transportation, including accessible transportation?

☐ Yes
☐ No

6. If your emergency warning systems use sirens or other audible alerts, do you have written procedures to ensure the use of a combination of methods to provide prompt notification of

emergencies to persons who are deaf or hard of hearing? (Note: Examples of methods that may be effective in communicating emergencies to people who are deaf or hard of hearing include auto-dialed TTY and taped telephone messages, text messaging, emails, open captioning on emergency broadcasts on local television stations, and dispatching qualified sign language interpreters to assist with emergency announcements that are televised.)

- ☐ Yes
- ☐ No

7. Does your plan address the needs of people with disabilities who will require assistance leaving their homes?

- ☐ Yes
- ☐ No

8. Do you have written procedures to ensure that your community evacuation plans enable people with a wide variety of disabilities to safely self-evacuate and, for those who cannot self-evacuate, to receive evacuation assistance? (Note: The plans should address the evacuation needs of people who have mobility disabilities, people who are blind or have low vision, people who are deaf or hard of hearing, people with cognitive and psychiatric disabilities, people with disabilities who use service animals, and other people with disabilities who reside or visit your community who may need evacuation assistance.)

- ☐ Yes
- ☐ No

9. Have you established a voluntary, confidential registry for persons with disabilities to request individualized notification, evacuation assistance, and transportation?

- ☐ Yes
- ☐ No

a. If you maintain such a registry, do you have written procedures to ensure that it is voluntary, it has appropriate confidentiality controls, the information in the registry is regularly updated, and outreach to persons with disabilities and organizations with expertise on disability issues is conducted to inform them of its availability?

- ☐ Yes
- ☐ No
- ☐ N/A

10. Does your emergency transportation plan identify accessible transportation resources that will be available to evacuate persons with mobility disabilities, including people who use wheelchairs or scooters, people who use medical equipment, such as oxygen tanks, and people who use service animals? (Accessible transportation consists of wheelchair lift-equipped vehicles.)

- ☐ Yes
- ☐ No

11. Do your emergency plans, policies, and procedures provide for people with disabilities to be evacuated and transported to shelters together with their families?

- ☐ Yes
- ☐ No

12. Do your emergency management plans, policies, and procedures ensure that people with disabilities are not separated from their service animals during evacuation and transportation?

- ☐ Yes
- ☐ No

ACTIONS:

If the answer to any of the above questions is "No," this is a red flag that your emergency management program may not be fully accessible to people with disabilities. Here are some steps to ensure that your emergency notification and evacuation policies, procedures, and programs are accessible to people with disabilities.

- ✓ If you use emergency warning systems such as sirens or audible alerts, provide alternate ways to provide prompt notification of emergencies to people who are deaf or hard of hearing. Combine visual and audible alerts to reach a greater audience than either method would reach by itself. Consider using telephone calls with pre-recorded messages, auto-dialed TTY (teletypewriter) messages, text messaging, emails, and direct door-to-door contact with pre-registered individuals. Also use open captioning on emergency broadcasts on local television stations and dispatch qualified sign language interpreters when emergency announcements are televised.

- ✓ Adopt policies to ensure that your community evacuation plans enable people with disabilities, including those who have mobility, vision, hearing, cognitive, and psychiatric disabilities, to safely self-evacuate or be evacuated by others.

- ✓ Create voluntary, confidential registries of persons with disabilities who may need individualized notification, evacuation assistance, and/or transportation. Establish procedures to ensure that the registries are voluntary, guarantee confidentiality to those who register, and include a process to periodically update the information contained in the registry. Widely publicize the registries, including outreach to people with disabilities, organizations with expertise on disability issues, organizations that provide services to people with disabilities, and paratransit riders. Outreach should explain the purpose of the registries, provide assurances of confidentiality, explain procedures for registering, and include procedures for people who, because of their disabilities, need assistance in registering.

- ✓ Identify accessible modes of transportation, such as wheelchair lift-equipped school buses, transit buses, paratransit vans, and taxi cabs that will be available to help evacuate people with disabilities during an emergency. Ensure that your plan addresses the needs of people with disabilities, including those who use wheelchairs, scooters, medical equipment, and service animals as well as those who will need assistance getting from their homes to emergency transportation pickup locations or staging areas.

Training First Responders, Staff, and Volunteers

13. Have the following categories of individuals been trained on the information provided in Chapter 7, including Addenda 2 and 3?

a. Emergency planners, those who designate facilities to be used as shelters, and those who make advance arrangements to address emergency staffing, equipment, medical supplies, food and beverages, and other emergency-related needs?

☐ Yes
☐ No

b. Staff and volunteers who participate in notification activities?

☐ Yes
☐ No

c. First responders and other staff and volunteers who deal with evacuation, transportation, and emergency-related security issues?

☐ Yes
☐ No

d. Shelter staff and volunteers and those who will be involved in routing people to shelters and deciding shelter placements for people with disabilities and their families?

☐ Yes
☐ No

e. Individuals involved in establishing and operating temporary housing or lodging programs?

☐ Yes
☐ No

f. Individuals who will establish and operate emergency-related medical and social service programs?

☐ Yes
☐ No

g. Individuals who will be responsible for repair, rebuilding, and continuity of program operations following an emergency or disaster?

☐ Yes
☐ No

ACTIONS:

If the answer to any of the above questions is "No," this is a red flag that your training programs for emergency management personnel and volunteers may not adequately address access issues for people with disabilities. Here are some steps to ensure that your training policies, procedures, and programs ensure access for people with disabilities.

- ✓ Ensure that emergency planners, those involved in emergency preparedness, first responders, and those involved in all other aspects of emergency management are trained in the requirements of Title II of the ADA, including the information provided in Chapter 7 and Addenda 2 and 3.

- ✓ Develop instructions for staff and volunteers who will perform duties related to emergency notification, evacuation, transportation, and the routing of people with disabilities and their families to, and placement of these individuals in, shelters.

- ✓ Develop site-specific instructions and training materials for "mass care," "medical," and "special needs" shelter volunteers and staff to ensure compliance with ADA requirements to provide access to programs, services, and activities offered at the shelter, and to address any concerns raised by, people with disabilities. Include in the instructions and training materials, the information in this Chapter, including Addenda 2 and 3, on shelter accessibility, eligibility criteria, effective communication, reasonable modifications in policies, practices, and procedures for service animals, and other reasonable modifications.

- ✓ Train individuals involved in the emergency management process to recognize issues that may affect people with a variety of disabilities and on the procedures to follow when access issues for individuals with disabilities arise during the course of an emergency or disaster, such as contacting your entity's ADA Incident Manager for guidance.

Physical Accessibility in Emergency Shelter Programs

This section helps you identify architectural barriers to access in your emergency shelter facilities. To ensure an accurate assessment of ADA compliance, this checklist should be completed with the input and assistance of those employees, volunteers, and representatives of third party organizations that are involved in your emergency planning and sheltering programs.

14. Have you conducted an accessibility survey of all of your emergency shelter facilities, whether owned by government or a private entity to determine if they comply with ADA requirements? See "Checklist for Accessible Emergency Shelters," included in Addendum 3 to this Chapter.

☐ Yes
☐ No

15. Have you identified access barriers at any of the shelter facilities?

☐ Yes
☐ No

16. If you found barriers at emergency shelters, have you taken steps to ensure that the barriers are removed to provide (at a minimum) the following accessible features that comply with the requirements of the ADA Standards for Accessible Design (ADA Standards): parking, exterior route from the parking to the entrance, entrance, sleeping area, dining area, toilet facilities, bathing facilities, recreational areas, emergency exit, and interior routes to all of these areas?

☐ Yes
☐ No
☐ N/A

17. If all barriers have not been removed from a shelter, have you identified an appropriate number of alternate shelters that provide (at a minimum) the following accessible features that comply with the requirements of the ADA Standards: parking, exterior route from the parking to the entrance, entrance, sleeping area, dining area, toilet facilities, bathing facilities, recreational areas, emergency exit, and interior routes to all of these areas?

☐ Yes
☐ No
☐ N/A

18. Until all emergency shelters have the required accessible features referenced above, have you identified and widely publicized to the public and to persons with disabilities and disability organizations the most accessible emergency shelters and the accessible features that each has?

☐ Ye
☐ No
☐ N/A

19. Have you adopted policies and procedures to ensure that shelter staff and volunteers maintain accessible routes for individuals who use wheelchairs and other mobility aids?

☐ Yes
☐ No

20. Have you adopted procedures to minimize protruding objects and overhead objects in shelters so that someone who is blind or has low vision can walk safely throughout the shelter?

☐ Yes
☐ No

21. Have you adopted policies and procedures for shelter staff and volunteers to offer wayfinding assistance to people who are blind and those with low vision who may need assistance in understanding and navigating the shelter layout and locating shelter facilities (e.g., finding the route to the toilet room when furniture layouts change)?

- ☐ Yes
- ☐ No

22. Have you established policies and procedures to ensure that, in the future, facilities are surveyed for accessibility and barriers to access are removed before a facility is designated as a shelter?

- ☐ Yes
- ☐ No

ACTIONS:

If the answer to any of the above questions is "No," this is a red flag that your emergency shelter program may not be fully accessible to people with disabilities. Here are some steps to ensure that your emergency shelters are physically accessible to people with disabilities.

- ✓ Survey your community's shelters for barriers to access for persons with disabilities. At a minimum, survey the parking, the path to the entrance, the entrance, sleeping and dining areas, toilet facilities, bathing facilities, first aid/medical facilities, recreation areas, and the routes to all of these areas. To conduct your survey, use the Department's technical assistance publication, "Checklist for Accessible Emergency Shelters," which is included in Addendum 3 to this Chapter.
  - If you find barriers to access, remove the barriers or work with the facility's owner to remove the barriers.
  - If barriers cannot be removed, find another nearby facility that is – or can be made – accessible.
  - Until all emergency shelters have the required accessible features (parking, route to the entrance, entrance, sleeping and dining areas, toilet facilities, bathing facilities, first aid/medical facilities, recreation areas, and the routes to all of these areas), identify and widely publicize the location and features of the most accessible emergency shelters to the public, including specific outreach to persons with disabilities, disability rights organizations, and organizations that provide services to people with disabilities.
- ✓ Adopt procedures to ensure that shelter staff and volunteers maintain accessible routes and minimize protruding objects. Beds and other furniture must be placed to ensure that accessible routes are not blocked, and that protruding and overhead objects are minimized in all areas of the shelter.
- ✓ Also include procedures for staff and volunteers to offer wayfinding assistance to people who are blind or have low vision to provide orientation to the shelter environment and assistance in locating shelter areas or features.
- ✓ Establish policies and procedures to ensure that facilities being considered as possible emergency shelters in the future are surveyed for accessibility using the "ADA Checklist for Emergency Shelters" and that barriers to access are removed before facilities are designated as emergency shelters.

Policies and Procedures in Emergency Shelters

23. Do you have supplies of informational materials routinely handed out at emergency shelters available in alternative formats (Braille, large print) for people who are blind or have low vision?

☐ Yes
☐ No

24. Have you adopted policies and procedures for shelter staff and volunteers to provide assistance to people who are blind or have low vision by reading and completing forms and other written materials that are not available in alternative formats?

☐ Yes
☐ No

25. Do any of your shelters have low-stimulation "stress-relief zones," such as an empty classroom in a school building used as an emergency shelter?

☐ Yes
☐ No

- If you offer "stress-relief zones," have you adopted policies and procedures to make these areas available on a priority basis to people whose disabilities are aggravated by stress?

  ☐ Yes
  ☐ No
  ☐ N/A

26. Have you adopted emergency shelter eligibility policies and procedures to ensure that people with disabilities are housed at "mass care" shelters unless they are medically fragile?

☐ Yes
☐ No

27. Have you adopted "mass care" shelter procedures to ensure that shelter staff and volunteers do not turn away people with disabilities who may need assistance with activities of daily living even though their personal care aides may not be with them?

☐ Yes
☐ No

28. Have you adopted policies and procedures to ensure that "mass care," "special needs," and "medical" shelter staff and volunteers are trained and monitored so they provide safe, appropriate assistance with activities of daily living (e.g., eating, dressing, personal hygiene, transferring to and from wheelchairs) that some people with disabilities may require?

☐ Yes
☐ No

29. If you provide a "special needs" or "medical" shelter, have you adopted eligibility policies and procedures to ensure that people with disabilities are not housed in such shelters just because they have a disability? (Note: Special needs and medical shelters are for medically fragile people who require the type of care provided in hospitals and nursing homes. Most people with disabilities are not medically fragile. The ADA requires emergency managers and shelter operators to accommodate people with disabilities in the most integrated setting appropriate to their needs.)

- ☐ Yes
- ☐ No
- ☐ N/A

30. Have your shelter staff and volunteers received training with site-specific instructions for providing people with disabilities access to all services, activities, and programs at "mass care," "medical," and "special needs" shelters?

- ☐ Yes
- ☐ No

31. Do you have written policies and procedures to ensure that people who are deaf or hard of hearing, people with speech disabilities, and people who are blind or have low vision are provided with effective communication during their stay at a shelter?

- ☐ Yes
- ☐ No

32. Do you provide a TTY at each emergency shelter for use by people who are deaf, are hard of hearing, or have speech disabilities?

- ☐ Yes
- ☐ No

33. Do you have written procedures to ensure that persons with disabilities who use service animals are not separated from their service animals when using emergency shelters and have full access to shelter programs, services, and activities, even if pets are normally prohibited in shelters or in certain areas of shelters?

- ☐ Yes
- ☐ No

34. Do you have written procedures to ensure that food, water, and a receptacle and plastic bags for the disposal of service animal waste are available at emergency shelters?

- ☐ Yes
- ☐ No

35. Have you established security procedures at shelters that allow people with service animals to take their animals outside for relief without unnecessary delays for security screening upon re-entry?

☐ Yes
☐ No

36. Do you have written procedures to ensure that emergency shelters have back-up generators and a way to keep medications refrigerated (such as a refrigerator or a cooler with ice)?

☐ Yes
☐ No

37. Do your written procedures on back-up generators include a plan for routinely notifying the public and disability groups of the location of shelters providing electricity and refrigeration?

☐ Yes
☐ No

38. Does your emergency management plan provide an effective way for people with disabilities to request and receive durable medical equipment and medication while in shelters?

☐ Yes
☐ No

39. Have you established procedures for people with disabilities to request and receive cots or beds, modifications to cots or beds, securement of cots or beds to allow safe transfer to a wheelchair, and placement of cots or beds in specific locations when needed?

☐ Yes
☐ No

40. Have you adopted kitchen access policies to provide immediate access to food and refrigerated medications for shelter residents and volunteers whose disabilities may require it?

☐ Yes
☐ No

41. Does your emergency management plan ensure that at least some kinds of foods and beverages are available in emergency shelters for people with dietary restrictions, such as people who have diabetes or severe food allergies?

☐ Yes
☐ No

ACTIONS:

If the answer to any of the above questions is "No," this is a red flag that your emergency shelter program may not be fully accessible to people with disabilities. Here are some steps to ensure that the policies and procedures relating to your emergency shelter programs are accessible to people with disabilities.

- ✓ Adopt procedures to provide effective communication for people who are deaf or hard of hearing, people with severe speech disabilities, and people who are blind or have low vision. Train staff on the basic procedures for providing effective communication, including exchanging notes or posting written announcements to go with spoken announcements. Provide a TTY in each shelter for persons who are deaf, are hard of hearing, or have speech disabilities. Provide interpreters when necessary to ensure effective communication. Train staff and volunteers to read printed information, upon request, to persons who are blind or who have low vision.

- ✓ If space permits, offer low-stimulation "stress-relief zones." Adopt policies and procedures to make these areas available on a priority basis to people whose disabilities are aggravated by stress.

- ✓ Adopt eligibility policies and procedures that ensure that people with disabilities are housed in "mass care" shelters unless they are medically fragile. The procedures should ensure that shelter staff and volunteers accept people with disabilities who need some assistance with activities of daily living even though their personal care aides may not be with them. Also, provide training and monitoring for staff and volunteers on safe, appropriate procedures for providing assistance in daily living activities to people with disabilities who require such assistance.

- ✓ If you provide a "special needs" or "medical" shelter, adopt eligibility policies and procedures to ensure that emergency managers do not require people with disabilities to stay in these shelters solely because they have a disability. Special needs and medical shelters are intended to house people who are medically fragile, such as those who require hospital or nursing home care. The ADA requires emergency managers and shelter operators to accommodate people with disabilities in the most integrated setting appropriate to their needs.

- ✓ Modify "no pets" policies to allow people with disabilities to stay in shelters – and participate in shelter programs, services, and activities – with their service animals. Also, provide food, water, and waste disposal supplies for service animals.

- ✓ Ensure that a reasonable number of shelters have back-up generators and a way to keep medications refrigerated (such as a refrigerator or a cooler with ice). Make these shelters refrigeration. Until all shelters have back-up generators and refrigeration

capacity, routinely notify the public about the location of the shelters that have these features.

- ✓ Establish policies and procedures ensuring that people who need electricity for life-sustaining equipment have priority access to it when it is available and that priority access is also provided, where feasible, for people with disabilities who rely on electrically powered mobility devices.

- ✓ Establish policies and procedures, and make advance arrangements for resources to ensure that there is an effective way for people with disabilities to request and receive durable medical equipment and medication.

- ✓ Establish policies and procedures and make advance resource arrangements so that people with disabilities can request cots and beds, modifications to cots and beds, securement of cots and beds, and specific placement of cots, beds, or sleeping mats when needed. In shelters where people will generally be expected to use sleeping mats placed on the floor, ensure that some cots and beds are available for people with disabilities who are unable to use sleeping mats. The procedures on cots and beds should provide for staff and volunteers to consult with people with disabilities about their needs and provide necessary accommodations.

- ✓ Modify kitchen-access policies so that residents and volunteers whose disabilities may require it can obtain immediate access to food and refrigerated medication. Also, in planning food supplies for shelters, ensure that at least some kinds of foods and beverages are available for people with dietary restrictions, such as diabetes or severe food allergies.

Medical and Social Services

42. Have you established policies and procedures to ensure that medical and social services and other benefit programs are accessible to people with disabilities, including people who use wheelchairs, scooters, and other mobility aids, individuals who cannot leave shelters because of their disabilities, and people who use service animals?

- ☐ Yes
- ☐ No

43. Have you established policies and procedures to ensure that application processes for benefit programs are designed so they do not exclude people with disabilities whose disabilities prevent them from using one particular type of application process (e.g., web-based application processes,

telephone-based application processes, procedures requiring applicants to have a valid driver's license, or procedures requiring applicants to apply in person)?

- ☐ Yes
- ☐ No

44. Do you have policies and procedures to ensure that your medical, social service, and other benefit programs provide effective communication to people with disabilities, including people who are deaf or hard of hearing and people who are blind or have low vision?

- ☐ Yes
- ☐ No

- Do your policies and procedures include primary consideration of the communication method preferred by an individual with a disability?

  - ☐ Yes
  - ☐ No
  - ☐ N/A

ACTIONS:

If the answer to any of the above questions is "No," this is a red flag that the medical and social services your entity provides may not be fully accessible to people with disabilities. Here are some steps to ensure that the policies and procedures relating to your medical and social services are accessible to people with disabilities.

- ✓ Establish policies and procedures to ensure that medical, social service, and other benefit programs are accessible to people with disabilities, including people who use wheelchairs, scooters, and other mobility aids and people who use service animals.
- ✓ Establish policies and procedures to ensure that medical, social service, and other benefit programs do not have eligibility criteria that screen out or tend to screen out people with disabilities, or application processes or procedures that deny access to people with disabilities.
- ✓ Establish policies and procedures to ensure that medical, social service, and other benefit programs provide effective communication to people with disabilities, including primary consideration of the method of communication preferred by an individual with a disability.

Post-Sheltering Policies and Procedures

45. Have you adopted procedures to provide additional time, transportation, and search assistance for people with disabilities in emergency shelters to locate accessible temporary housing and support services in the community following an emergency?

- ☐ Yes
- ☐ No

46. If you have a program to provide temporary housing to persons when they leave emergency shelters but cannot yet return home (e.g., housing in dormitories, rooms at lodging facilities, trailers), have you adopted a plan for providing prompt, equivalent temporary housing to persons with disabilities, including accessible housing for people who use wheelchairs, scooters, and other mobility aids and people who are deaf or hard of hearing?

- ☐ Yes
- ☐ No
- ☐ N/A

47. If you have a temporary housing program, do your information materials on temporary housing include information on accessible housing (such as the specific location of accessible hotel rooms within the community or in nearby communities and transportation resources available in that area)?

- ☐ Yes
- ☐ No
- ☐ N/A

ACTIONS:

If the answer to any of the above questions is "No," this is a red flag that your emergency management and post-shelter programs may not be fully accessible to people with disabilities. Here are some steps to ensure that your post-shelter policies, procedures, and programs are accessible to people with disabilities.

- ✓ Modify policies, as necessary, to provide transportation, search assistance, and additional time in shelters to individuals with disabilities who are attempting to locate housing.

- ✓ Identify temporary accessible housing (such as accessible hotel rooms within the community or in nearby communities) that could be used if people with disabilities cannot immediately return home after a disaster. Consider establishing temporary housing procedures to ensure that accessible hotel rooms are available on a priority basis to people with disabilities who need them.

- ✓ Establish policies and procedures to ensure that temporary housing information distributed to the public or to shelter residents includes information on accessible housing and transportation resources.

Post-Emergency Repair, Rebuilding, and Resumption of Program Operations

48. Have you established policies and procedures to ensure that the repair and rebuilding of government facilities comply with the accessibility requirements of Title II of the ADA?

- ☐ Yes
- ☐ No

49. Have you established policies to ensure that programs relocated from a damaged facility on a temporary or permanent basis remain accessible to people with disabilities?

- ☐ Yes
- ☐ No

ACTIONS:

If the answer to any of the above questions is "No," this is a red flag that your post-emergency policies and procedures may not be fully accessible to people with disabilities. Here are some steps to ensure that your post-emergency policies and procedures ensure access for people with disabilities.

- ✓ Establish policies and procedures to ensure that facilities constructed or altered because of emergency- or disaster-related damage comply with the accessibility requirements of Title II of the ADA. Facilities constructed after January 26, 1992, and repairs to such facilities, must comply with Title II's new construction requirements. Alterations to facilities constructed before the ADA became effective, must comply with Title II's requirements for alterations to existing facilities. Alterations may not decrease accessibility.

- ✓ Establish policies and procedures to ensure that programs relocated from a damaged facility remain accessible to people with disabilities, whether the relocation is permanent or temporary. Ensure that continuity of operations plans address continuity of access to programs, services, and activities for people with disabilities. Ensure that repair and clean-up activities include the maintenance of accessible features.

Chapter 7 Addendum 1: Title II Checklist
(Emergency Management)
(July 26, 2007)

ADA Best Practices Tool Kit for State and Local Governments

Chapter 3 Addendum:

Title II Checklist

(General Effective Communication)

PURPOSE OF THIS CHECKLIST: This checklist is designed for use as an assessment of a **state or local government's provision of effective communication.**

MATERIALS AND INFORMATION NEEDED: To assess compliance with the general effective communication requirements, you will need:

- ✓ a copy of any policies or procedures related to providing sign language interpreters, oral interpreters, cued speech interpreters, notetakers, computer-aided transcription services, etc., when requested by members of the general public. If different departments have different policies, you should review each of the policies.

- ✓ a list of printed materials provided to the public by the locality and an indication of whether these materials are provided, upon request, in an accessible format, such as in large print, Braille, or audio recording.

- ✓ a list of any videos or television programs produced by the locality and an indication of whether these videos or programs have captioning and audio descriptions.

- ✓ a list of where teletypewriters (TTYs) are provided by the locality.

- ✓ a copy of any training materials used in training government employees about providing effective communication to members of the general public whose disabilities affect communication.

Interpreters (Sign Language, Oral, and Cued Speech)

1. Does each department of your state or local government have a policy and procedures in place to deal with requests from the general public for sign language, oral, and cued speech interpreters?

☐ Yes
☐ No

2. If policies and procedures are in place, do they:

a. Specify that sign language, oral, and cued speech interpreters can be obtained within a short period of time when necessary? (For example, when needed for hospital emergency rooms, interpreters should be available either in person or by using video relay systems within a reasonable period of time, 24 hours a day, 7 days a week – in this setting, reasonable usually means within an hour of a request. In non-emergency situations, a public entity can require reasonable advance notice for interpreter requests.)

☐ Yes
☐ No

b. Make clear that it is generally inappropriate to request family members and companions of deaf persons to serve as sign language interpreters?

☐ Yes
☐ No

c. Specify that deaf persons requesting interpreters should not be charged for the cost of the interpreter?

☐ Yes
☐ No

d. Specify that the public entity's decision to deny an interpreter based on undue financial and administrative burden must be made after considering all resources available for use in funding the operation of the program and must be accompanied by a written statement of the reasons for reaching the conclusion?

☐ Yes
☐ No

e. Specify that, in any instance where the provision of an interpreter would result in an undue financial and administrative burden, the entity will take any other action that would not result in an undue financial and administrative burden but would nevertheless ensure that the individual with a disability receives the benefits or services provided?

☐ Yes
☐ No

3. Does your state or local government have employees on staff who are qualified interpreters or have arrangements with one or more vendors to provide interpreting services when needed?

☐ Yes
☐ No

4. Have the employees who interact with the public been trained on the correct procedures to follow when a person requests an interpreter?

☐ Yes
☐ No

5. Review documentation and speak with agency personnel responsible for responding to requests for interpreter services. When requests for interpreters have been made in the past, were they granted:

a. For events such as meetings, interviews, hearings, medical appointments, court proceedings, and training and counseling sessions?

☐ Yes
☐ No

b. Without the state or local government asking the individual who requested the interpreter charged to pay for the services?

☐ Yes
☐ No

ACTIONS:

If you checked "no" to any of the questions above, these are red flags indicating that your state or local government may not be complying with the effective communication requirements of Title II of the ADA.

- ✓ If your entity does not have policies and procedures on the provision of interpreters, they need to be established.

- ✓ If your entity has policies and procedures, make sure they include the following provisions:
  - Sign language, oral, and cued speech interpreters can be obtained within a short period of time when necessary. In emergency situations, sign language interpreters will be available either in person or by using video relay systems within a reasonable period, 24 hours a day, 7 days a week – usually, within an hour of receiving the request. In non-emergency situations, sign language interpreters will be available when reasonable advance notice is provided.
  - Family members and companions of deaf persons will not be asked to serve as sign language interpreters.
  - Deaf persons requesting interpreters will not be charged or asked to pay for the cost of an interpreter.

- In situations where agency personnel believe that an undue financial and administrative burden may be involved, the decision to deny an interpreter will be made considering all funding available for the operation of the program.
- Where undue financial and administrative burden is the basis for the denial of an interpreter, the agency will take any other action that would not result in an undue financial and administrative burden but would ensure that the individual with a disability receives the benefits or services provided.

✓ Make the policy and procedures on the provision of interpreters available to your employees and the public by posting it on your entity's website.

✓ Train employees so they know the policies and the appropriate procedures to follow when they receive a request for an interpreter.

✓ Make arrangements with vendors or hire employees so interpreters are available when needed.

Other Auxiliary Aids and Services

6. Does your state or local government have policies and procedures in place to deal with requests from the general public for documents in Braille, large print, audio recording, and accessible electronic format (that is, an email or compact disc containing the document in plain text, word processing format, HTML or some other format that can be accessed with screen reader software)?

☐ Yes
☐ No

7. Does your state or local government have policies and procedures in place to deal with requests from the general public for notetakers, computer-assisted real-time transcription services, and other auxiliary aids and services for providing effective communication?

☐ Yes
☐ No

8. Does your state or local government have the equipment or arrangements with vendors so it can provide written materials in alternative formats (e.g., Braille, large print, audio format, electronic format)?

☐ Yes
☐ No

9. Does your state or local government provide written materials in alternative formats when asked to do so? (For example, does your entity communicate with blind people by using Braille, large print, or email when asked to do so?)

- ☐ Yes
- ☐ No

10. Does your state or local government give primary consideration to the requests of the person with a disability when determining what type of auxiliary aid or service to provide?

- ☐ Yes
- ☐ No

11. Does your entity ensure that all videos and television programs it produces and all videos it makes available to the public on its internet website are available with captioning and audio description?

- ☐ Yes
- ☐ No

ACTIONS:

If you checked "no" for any of the questions above, your state or local government may not be providing effective communication. Consider taking the following steps:

- ✓ Ensure that policies and procedures are in place to provide auxiliary aids and services needed to ensure effective communications. Policies and procedures should address common requests, such as (1) making documents available upon request in Braille, large print, audio recording, and an accessible electronic format, and (2) providing notetakers, computer-aided real-time transcription, assistance in reading and completing forms, and other common auxiliary aids and services. See the list of common auxiliary aids and services on page 3 of Chapter 3.

- ✓ Ensure that your entity's policies and procedures require decision makers to give primary consideration to the auxiliary aid or service requested by the person with a disability when deciding which auxiliary aid or service to provide.

- ✓ Purchase equipment or make arrangements with vendors so that documents can be provided in alternative formats when requested.

- ✓ Make all videos and television programs that your entity produces, distributes, or makes available to the public accessible to people with hearing and vision disabilities by providing captioning and audio description of important visual images, unless doing so

would be a fundamental alteration of your program or impose an undue financial and administrative burden.

- ✓ Train your entity's employees who interact with the public so they know what to do when they receive a request for an auxiliary aid or service.

- ✓ Publish your effective communication policy on the entity's website in an accessible format so people with disabilities know about any reasonable advance notice requirements that your entity adopts.

- ✓ Meet with people in your community who have different disabilities to find out how well your entity's effective communication policies and procedures are working and to solicit suggestions for improvement.

TTYs

12. Where telephones are available to the public for making outgoing calls, are TTYs available for people with hearing and speech disabilities?

- ☐ Yes
- ☐ No

13. Does your state or local government handle calls placed using a Telecommunications Relay Service or a Video Relay Service in the same way as other telephone calls?

- ☐ Yes
- ☐ No

ACTIONS:

If you checked "no" for either of the questions above, your entity may be violating the requirement for providing equally effective telecommunication systems for people with hearing and speech disabilities.

- ✓ Provide access to a TTY wherever telephones are available for making outgoing calls.

- ✓ Provide written policies and training to employees who answer the telephone to ensure that incoming calls made through a relay service are handled as quickly and effectively as other calls.

- ✓ Meet with deaf people in your community to find out their experiences when using a relay service to call your entity.

Chapter 3

General Effective Communication Requirements Under Title II of the ADA

In this chapter, you will learn about the requirements of Title II of the ADA for effective communication. Questions answered include:

- What is effective communication?
- What are auxiliary aids and services?
- When is a state or local government required to provide auxiliary aids and services?
- Who chooses the auxiliary aid or service that will be provided?

A. Providing Equally Effective Communication

Under Title II of the ADA, all state and local governments are required to take steps to ensure that their communications with people with disabilities are as effective as communications with others.[1] This requirement is referred to as "effective communication"[2] and it is required except where a state or local government can show that providing effective communication would fundamentally alter the nature of the service or program in question or would result in an undue financial and administrative burden.

What does it mean for communication to be "effective"? Simply put, "effective communication" means that **whatever is written or spoken must be as clear and understandable to people with disabilities as it is for people who do not have disabilities**. This is important because some people have disabilities that affect how they communicate.

How is communication with individuals with disabilities different from communication with people without disabilities? For most individuals with disabilities, there is no difference. But people who have disabilities that affect hearing, seeing, speaking, reading, writing, or understanding may use different ways to communicate than people who do not.

> The effective communication requirement applies to ALL members of the public with disabilities, including job applicants, program participants, and even people who simply contact state or local government agencies seeking information about programs, services, or activities.

[1] DeDepartment of Justice Nondiscrimination on the Basis of State and Local Government Services Regulations, 28 C.F.R. Part 35, § 35.160 (2005). The Department's Title II regulation is available at www.ada.gov/reg2.htm.

[2] See Department of Justice Americans with Disabilities Act Title II Technical Assistance Manual II-7.1000 (1993). The Technical Assistance Manual is available at www.ada.gov/taman2.html.

1. Providing Equal Access with Auxiliary Aids and Services

There are many ways that you can provide equal access to communications for people with disabilities. These different ways are provided through "auxiliary aids and services." **"Auxiliary aids and services" are devices or services that enable effective communication for people with disabilities.**[3]

Title II of the ADA requires government entities to make appropriate auxiliary aids and services available to ensure effective communication.[4] You also must make information about the location of accessible services, activities, and facilities available in a format that is accessible to people who are deaf or hard of hearing and those who are blind or have low vision.[5]

Generally, the requirement to provide an auxiliary aid or service is triggered when a person with a disability requests it.

[3] 28 C.F.R. §§ 35. 104, 35.160.

[4] 28 C.F.R. Part 35.160(b)(1).

[5] 28 C.F.R. § 35.163 (a).

2. Different Types of Auxiliary Aids and Services

Here are some examples of different auxiliary aids and services that may be used to provide effective communication for people with disabilities. **But, remember, not all ways work for all people with disabilities or even for people with one type of disability. You must consult with the individual to determine what is effective for him or her.**

- qualified interpreters
- notetakers
- screen readers
- computer-aided real-time transcription (CART)
- written materials
- telephone handset amplifiers
- assistive listening systems
- hearing aid-compatible telephones
- computer terminals
- speech synthesizers
- communication boards
- text telephones (TTYs)
- open or closed captioning
- closed caption decoders
- video interpreting services
- videotext displays
- description of visually presented materials
- exchange of written notes
- TTY or video relay service
- email
- text messaging
- instant messaging
- qualified readers
- assistance filling out forms
- taped texts
- audio recordings
- Brailled materials
- large print materials
- materials in electronic format (compact disc with materials in plain text or word processor format)

B. Speaking, Listening, Reading, and Writing: When Auxiliary Aids and Services Must be Provided

Remember that communication may occur in different ways. Speaking, listening, reading, and writing are all common ways of communicating. When these communications involve a person with a disability, an auxiliary aid or service may be required for communication to be effective. The type of aid or service necessary depends on the length and complexity of the communication as well as the format.

1. Face-to-Face Communications

For brief or simple face-to-face exchanges, very basic aids are usually appropriate. For example, exchanging written notes may be effective when a deaf person asks for a copy of a form at the library.

For more complex or lengthy exchanges, more advanced aids and services are required. Consider how important the communication is, how many people are involved, the length of the communication anticipated, and the context.

Examples of instances where more advanced aids and services are necessary include meetings, hearings, interviews, medical appointments, training and counseling sessions, and court proceedings. In these types of situations where someone involved has a disability that affects communication, auxiliary aids and services such as qualified interpreters, computer-aided real-time transcription (CART), open and closed captioning, video relay, assistive listening devices, and computer terminals may be required. Written transcripts also may be appropriate in pre-scripted situations such as speeches.

Computer-Aided Real-Time Transcription (CART)

Many people who are deaf or hard of hearing are not trained in either sign language or lip-reading. CART is a service in which an operator types what is said into a computer that displays the typed words on a screen.

2. Wri2. Written Communications

Accessing written communications may be difficult for people who are blind or have low vision and individuals with other disabilities. Alternative formats such as Braille, large print text, emails or compact discs (CDs) with the information in accessible formats, or audio recordings are often effective ways of making information accessible to these individuals. In instances where information is provided in written form, ensure effective communication for people who cannot read the text. Consider the context, the importance of the information, and the length and complexity of the materials.

When you plan ahead to print and produce documents, it is easy to print or order some in alternative formats, such as large print, Braille, audio recordings, and documents stored electronically in accessible formats on CDs. Some examples of events when you are likely to produce documents in advance include training sessions, informational sessions, meetings, hearings, and press conferences. In many instances, you will receive a request for an alternative format from a person with a disability before the event.

If written information is involved and there is little time or need to have it produced in an alternative format, reading the information aloud may be effective. For example, if there are brief written instructions on how to get to an office in a public building, it is often effective to read the directions aloud to the person. Alternatively, an agency employee may be able to accompany the person and provide assistance in locating the office.

Don't forget . . .

Even tax bills and bills for water and other government services are subject to the requirement for effective communication. Whenever a state or local government provides information in written form, it must, when requested, make that information available to individuals who are blind or have low vision in a form that is usable by them.

3. Primar3. Primary Consideration: Who Chooses the Auxiliary Aid or Service?

When an auxiliary aid or service is requested by someone with a disability, you must provide an opportunity for that person to request the auxiliary aids and services of their choice, and you must give primary consideration to the individual's choice.[6] "Primary consideration" means that the public entity must honor the choice of the individual with a disability, with certain exceptions.[7] The individual with a disability is in the best position to determine what type of aid or service will be effective.

The requirement for consultation and primary consideration of the individual's choice applies to aurally communicated information (i.e., information intended to be heard) as well as information provided in visual formats.

The requesting person's choice does not have to be followed if:

- the public entity can demonstrate that another equally effective means of communication is available;
- use of the means chosen would result in a fundamental alteration in the service, program, or activity; or
- the means chosen would result in an undue financial and administrative burden.

Video Remote Interpreting (VRI) or Video Interpreting Services (VIS)

VRI or VIS are services where a sign language interpreter appears on a videophone over high speed internet lines. Under some circumstances, when used appropriately, video interpreting services can provide immediate, effective access to interpreting services seven days per week, twenty-four hours a day, in a variety of situations including emergencies and unplanned incidents.

On-site interpreter services may still be required in those situations where the use of video interpreting services is otherwise not feasible or does not result in effective communication. For example, using VRI/VIS may be appropriate when doing immediate intake at a hospital while awaiting the arrival of an in-person interpreter, but may not be appropriate in other circumstances, such as when the patient is injured enough to have limited mobility or needs to be moved from room to room.

VRI/VIS is different from Video Relay Services (VRS) which enables persons who use sign language to communicate well with voice telephone users through a relay service using video equipment. VRS may only be used when consumers are connecting to one another through a telephone connection.

[6] 28 C.F.R. Part 35.160 (b)(2).

[7] See Title II Technical Assistance Manual II-7.1100.

4. Providing Qualified Interpreters and Qualified Readers

When an interpreter is requested by a person who is deaf or hard of hearing, the interpreter provided must be qualified.

A "qualified interpreter" is someone who is able to sign to the individual who is deaf what is being spoken by the hearing person and who can voice to the hearing person what is being signed by the person who is deaf. Certification is not required if the individual has the necessary skills. To be qualified, an interpreter must be able to convey communications effectively, accurately, and impartially, and use any necessary specialized vocabulary.[8]

Similarly, those serving as readers for people who are blind or have low vision must also be "qualified."[9] For example, a qualified reader at an office where people apply for permits would need to be able to read information on the permit process accurately and in a manner that the person requiring assistance can understand. The qualified reader would also need to be capable of assisting the individual in completing forms by accurately reading instructions and recording information on each form, in accordance with each form's instructions and the instructions provided by the individual who requires the assistance.

Did You Know That There are Different Types of Interpreters?

Sign Language Interpreters
Sign language is used by many people who are deaf or hard of hearing. It is a visually interactive language that uses a combination of hand motions, body gestures, and facial expressions. There are several different types of sign language, including American Sign Language (ASL) and Signed English.

Oral Interpreters
Not all people who are deaf or hard of hearing are trained in sign language. Some are trained in speech reading (lip reading) and can understand spoken words more clearly with assistance from an oral interpreter. Oral interpreters are specially trained to articulate speech silently and clearly, sometimes rephrasing words or phrases to give higher visibility on the lips. Natural body language and gestures are also used.

Cued Speech Interpreters
A cued speech interpreter functions in the same manner as an oral interpreter except that he or she also uses a hand code, or cue, to represent each speech sound.

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8 28 C.F.R. § 35.104.
9 28 C.F.R. § 35.104.

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5. Television, Videos, Telephones, and Title II of the ADA

The effective communication requirement also covers public television programs, videos produced by a public entity, and telephone communications.[10] These communications must be accessible to people with disabilities.

a. Public Television and Videos

If your local government produces public television programs or videos, they must be accessible. A common way of making them accessible to people who are unable to hear the audio portion of these productions is closed captioning. For persons who are blind or have low vision, detailed audio description may be added to describe important visual images.

b. Telephone Communications

Public entities that use telephones must provide equally effective communication to individuals with disabilities. There are two common ways that people who are deaf or hard of hearing and those with speech impairments use telecommunication. One way is through the use of teletypewriters (TTYs) or computer equipment with TTY capability to place telephone calls. A TTY is a device on which you can type and receive text messages. For a TTY to be used, both parties to the conversation must have a TTY or a computer with TTY capability. If TTYs are

provided for employees who handle incoming calls, be sure that these employees are trained and receive periodic refreshers on how to communicate using this equipment.

A second way is by utilizing telephone relay services or video relay services. Telephone relay services involve a relay operator who uses both a standard telephone and a TTY to type the voice messages to the TTY user and read the TTY messages to the standard telephone user. Video relay services involve a relay operator who uses both a standard telephone and a computer video terminal to communicate voice messages in sign language to the computer video terminal user and to voice the sign language messages to the standard telephone user.

Public employees must be instructed to accept and handle relayed calls in the normal course of business. Untrained individuals frequently mistake relay calls for telemarketing or collect calls and refuse to accept them. They also may mistakenly assume that deaf people must come into a government office to handle a matter in person even though other people are allowed to handle the same matter over the telephone.

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[10] 28 C.F.R. §§ 35.104, 35.160, 35.161.

C. Planning Ahead to Provide Effective Communication

Even before someone requests an auxiliary aid or service from your public entity, plan ahead to accommodate the communication needs of persons with disabilities. Prepare for the time when someone will request a qualified interpreter, Braille documents, video relay, or another auxiliary aid or service.

- **Identify local resources for auxiliary aids and services.** Even if you do not think there is anyone with a disability in your community, you need to be prepared.

- **Find out how you can produce documents in Braille or acquire other aids or services.** Technology is changing, and much of the equipment needed to ensure effective communication is less expensive than it once was. Consider whether it makes sense to procure equipment or obtain services through vendors. If your needs will be best met by using vendors, identify vendors who can provide the aids or services and get information about how much advance notice the vendors will need to produce documents or provide services.

- **Contract with qualified interpreter services and other providers so that interpreters and other aids and services will be available on short notice.** This is especially critical for time-sensitive situations, such as when a qualified interpreter is necessary to communicate with someone who is arrested, injured, hospitalized, or involved in some other emergency.

- **Use the checklist included in this Chapter to assess your agency's ability to provide effective communication and to figure out the next steps for achieving ADA compliance.**

- **Train employees about effective communication and how to obtain and use auxiliary aids and services. All employees who interact with the public over the telephone or in person need to know their role in ensuring effective communication.**

ADA Best Practices Tool Kit for State and Local Governments

Chapter 5 Addendum:

Title II Checklist
(Website Accessibility)

PURPOSE OF THIS CHECKLIST: This checklist is designed for use **in conducting a preliminary assessment of the accessibility of your agency's website**. The goal is to review your website and your agency's website policies and procedures and see if there are red flags alerting you to ADA accessibility concerns.

MATERIALS AND INFORMATION NEEDED: To assess the accessibility of your website you will need:

- ✓ If already created, a copy of your Website Accessibility Policy.
- ✓ Information describing specific actions taken to make your existing website accessible to people with disabilities.
- ✓ Information about website accessibility training taken by staff and/or contractors responsible for developing and posting webpages and content.
- ✓ Information about any procedures used to obtain input from people with disabilities regarding the accessibility of your website.
- ✓ Any input provided by people with disabilities about their experiences accessing your website.
- ✓ The assistance of your website manager.

Assessing Current Webpages and Content on Your Website

This section will help you determine if your website has some of the most common accessibility problems. It will not identify all website accessibility problems.

1. Does the top of each page with navigation links have a "skip navigation" link? (This feature directs screen readers to bypass the row of navigation links and start at the webpage content, thus enabling people who use screen readers to avoid having to listen to all the links each time they move to a new page.)

☐ Yes

☐ No

2. Do all links have a text description that can be read by a screen reader (not just a graphic or "click here")?

☐ Yes
☐ No

3. Do all of the photographs, maps, graphics and other images on the website currently have HTML tags (such as an "alt" tag or a long description tag) with text equivalents of the material being visually conveyed?

☐ Yes
☐ No

4. Are all of the documents posted on your website available in HTML or another text-based format (for example, rich text format (RTF) or word processing format), even if you are also providing them in another format, such as Portable Document Format (PDF)?

☐ Yes
☐ No

5. If your website has online forms, do HTML tags describe all of the controls (including all text fields, check boxes, drop-down lists, and buttons) that people can use in order to complete and submit the forms?

☐ Yes
☐ No
☐ N/A

6. If your website has online forms, does the default setting in drop-down lists describe the information being requested instead of displaying a response option (e.g., "your age" instead of "18 - 21")?

☐ Yes
☐ No
☐ N/A

7. If a webpage has data charts or tables, is HTML used to associate all data cells with column and row identifiers?

☐ Yes
☐ No
☐ N/A

8. Do all video files on your website have audio descriptions of what is being displayed to provide access to visually conveyed information for people who are blind or have low vision?

- ☐ Yes
- ☐ No
- ☐ N/A

9. Do all video files on your website have written captions of spoken communication synchronized with the action to provide access to people who are deaf or hard of hearing?

- ☐ Yes
- ☐ No
- ☐ N/A

10. Do all audio files on your website have written captions of spoken communication synchronized with the action to provide access to people who are deaf or hard of hearing?

- ☐ Yes
- ☐ No
- ☐ N/A

11. Have all webpages been designed so they can be viewed using visitors' web browser and operating system settings for color and font?

- ☐ Yes
- ☐ No

Website Accessibility Policy and Procedures

This section will help you identify potential problems with the ongoing process of ensuring website accessibility

12. Do you have a written policy on website accessibility?

- ☐ Yes
- ☐ No

13. Is the website accessibility policy posted on your website in a place where it can be easily located?

- ☐ Yes
- ☐ No
- ☐ N/A

14. Have procedures been developed to ensure that content is not added to your website until it has been made accessible?

☐ Yes
☐ No

15. Does the website manager check the HTML of all new webpages to confirm accessibility before the pages are posted?

☐ Yes
☐ No

16. When documents are added to your website in PDF format, are text-based versions of the documents (e.g., HTML, RTF, or word processing format) added at the same time as the PDF versions?

☐ Yes
☐ No
☐ N/A

17. Have in-house staff and contractors received information about the website accessibility policy and procedures to ensure website accessibility?

☐ Yes
☐ No
☐ N/A

18. Have in-house and contractor staff received appropriate training on how to ensure the accessibility of your website?

☐ Yes
☐ No

19. Have in-house and contractor staff who create web content or post it on your website received copies of the Department of Justice's technical assistance document "Accessibility of State and Local Government Websites to People with Disabilities"?

☐ Yes
☐ No

20. If your website contains inaccessible content, is a specific written plan including timeframes in place now to make all of your existing web content accessible?

☐ Yes
☐ No
☐ N/A - website is completely accessible

21. Have you posted on your website a plan to improve website accessibility and invited suggestions for improvements?

☐ Yes
☐ No

22. Does your website home page include easily locatable information, including a telephone number and email address, for use in reporting website accessibility problems and requesting accessible services and information?

☐ Yes
☐ No

23. Do you have procedures in place to assure a quick response to website visitors with disabilities who are having difficulty accessing information or services available via the website?

☐ Yes
☐ No

24. Have you asked disability groups representing people with a wide variety of disabilities to provide feedback on the accessibility of your website? (Note: Feedback from people who use a variety of assistive technologies is helpful in ensuring website accessibility.)

☐ Yes
☐ No

25. Have you tested your website using one of the products available on the Internet to test website accessibility? (Note: Products available for testing website accessibility include no-cost and low-cost options. These products may not identify all accessibility issues and may flag issues that are not accessibility problems. However, they are, nonetheless, a helpful tool in improving website accessibility.)

☐ Yes
☐ No

26. Are alternative ways of accessing web-based information, programs, activities, and services available for people with disabilities who cannot use computers?

☐ Yes
☐ No

ACTIONS:

If the answer to any of the above questions is "No," there may be accessibility problems with your website. Here are some steps to take to ensure that your website – and the programs and services offered on it – are accessible to people with disabilities.

- ✓ Establish a policy that your webpages will be accessible and create a process for implementation.
- ✓ Check the HTML of all new webpages. Make sure that accessible elements are used, including "alt" tags, long descriptions, and captions, as needed.
- ✓ Ensure that your webpages are designed in a manner that allows them to be displayed using a visitor's own settings for color and fonts.
- ✓ If images are used, including photos, graphics, scanned images, or image maps, make sure to include text equivalents for them, using "alt" tags and/or long descriptions for each. Ensure that the text equivalents convey the meaningful information presented visually by the image.
- ✓ If you use online forms and tables, make those elements accessible.
- ✓ Ensure that videos appearing on your website include appropriately synchronized audio description and captions.
- ✓ When posting new documents on the website, always provide them in HTML or another text-based format (even if you are also providing them in another format, such as PDF). If documents are provided in both formats, provide both formats at the same time so people with disabilities have the same degree of access as others.
- ✓ Develop a plan for making your existing web content accessible, including specific steps and timeframes. Describe your plan on an accessible webpage that can be easily located from your home page. Encourage input on accessibility improvements, including which pages should be given high priority for change. Let citizens know about the standards or guidelines that are being used to provide accessibility. Make accessibility modifications to the more popular webpages on your website a priority.
- ✓ Ensure that in-house staff and contractors responsible for webpages and webpage content development are properly trained on your web accessibility policy and procedures.
- ✓ Provide a way for visitors to request accessible information or services and provide feedback about accessibility problems by posting a telephone number and email address on your home page. Establish procedures to assure a quick response to people with disabilities who use this contact information to access web-based information or services.

accessibility and ease of use; use this information to increase your website accessibility.

- ✓ Consider using one of the no-cost or low-cost resources available on the Internet to test the accessibility of your website. (Please note, however, that these products may not identify all accessibility problems on your website.)
- ✓ Ensure that alternative means are available for people with disabilities who are unable to use computers to access information, programs, and services that are normally provided on your website

THE ADA, FMLA, AND WORKERS' COMPENSATION

	ADA	FMLA	WC
Purpose	Prohibits discrimination	Sets minimum leave standards	Provides for payment of compensation; rehabilitation
Who is subject to law	Employers with 15 or more employees	Employers with 50 or more employees	All employers
Who is protected	Qualified employee or applicant	Employee who has worked one year and 1,250 hours; 75 mile radius rule	Employee
What triggers protection	Disability; having an impairment; having had same, or being regarded as having had the same	A serious health condition, birth or adoption	Sustaining an injury or occupational disease.
Protection	Reasonable accommodation vs. undue hardship	12 weeks of leave	None
Medical leave, continuous or intermittent	Reasonable accommodation vs. undue hardship	12 weeks of leave if qualifies	None
Family Leave	No	Family member with serious health condition	No nursing services?
Medical certification of disability or condition	Employer can obtain if job-related or consistent with business necessity	Employer "may" require	No prohibition, but employee must submit medical proof to receive benefits
Time limit	Non-reasonable accommodation and undue hardship	12 weeks per year	Temporary total and wage loss issues
Light duty or restricted duty	May be reasonable accommodation	Focus is on position at time of request for leave	Loss of total disability benefits but may be eligible for wage loss

Certification of Health Care Provider for Employee's Serious Health Condition (Family and Medical

U.S. Department of Labor
Wage and Hour Division

OMB Control Number: 1235-0003
Expires: 5/31/2018

SECTION I: For Completion by the EMPLOYER

INSTRUCTIONS to the EMPLOYER: The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA protections because of a need for leave due to a serious health condition to submit a medical certification issued by the employee's health care provider. Please complete Section I before giving this form to your employee. Your response is voluntary. While you are not required to use this form, you may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. §§ 825.306-825.308. Employers must generally maintain records and documents relating to medical certifications, recertifications, or medical histories of employees created for FMLA purposes as confidential medical records in separate files/records from the usual personnel files and in accordance with 29 C.F.R. § 1630.14(c)(1), if the Americans with Disabilities Act applies, and in accordance with 29 C.F.R. § 1635.9, if the Genetic Information Nondiscrimination Act applies.

Employer name and contact: _____

Employee's job title: _____ Regular work schedule: _____

Employee's essential job functions: _____

_____

Check if job description is attached: _____

SECTION II: For Completion by the EMPLOYEE

INSTRUCTIONS to the EMPLOYEE: Please complete Section II before giving this form to your medical provider. The FMLA permits an employer to require that you submit a timely, complete, and sufficient medical certification to support a request for FMLA leave due to your own serious health condition. If requested by your employer, your response is required to obtain or retain the benefit of FMLA protections. 29 U.S.C. §§ 2613, 2614(c)(3). Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA request. 29 C.F.R. § 825.313. Your employer must give you at least 15 calendar days to return this form. 29 C.F.R. §825.305(b).

Your name: _____
First Middle Last

SECTION III: For Completion by the HEALTH CARE PROVIDER

INSTRUCTIONS to the HEALTH CARE PROVIDER: Your patient has requested leave under the FMLA. Answer, fully and completely, all applicable parts. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can; terms such as "lifetime," "unknown," or "indeterminate" may not be sufficient to determine FMLA coverage. Limit your responses to the condition for which the employee is seeking leave. Do not provide information about genetic tests, as defined in 29 C.F.R. § 1635.3(f), genetic services, as defined in 29 C.F.R. § 1635.3(e), or the manifestation of disease or disorder in the employee's family members, 29 C.F.R. § 1635.3(b). Please be sure to sign the form on the last page.

Provider's name and business address: _____

Type of practice / Medical specialty: _____

Telephone: (_____)_____ Fax:(_____)_____

PART A: MEDICAL FACTS

1. Approximate date condition commenced: _____

Probable duration of condition: _____

Mark below as applicable:

Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility? ___No__Yes. If so, dates of admission:

_____

Date(s) you treated the patient for condition:

Will the patient need to have treatment visits at least twice per year due to the condition? ___No ___ Yes.

Was medication, other than over-the-counter medication, prescribed? ___No ___Yes.

_____

Was the patient referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)? ____No___Yes. If so, state the nature of such treatments and expected duration of treatment:

2. Is the medical condition pregnancy? ___No ___Yes. If so, expected delivery date: _____

3. Use the information provided by the employer in Section I to answer this question. If the employer fails to provide a list of the employee's essential functions or a job description, answer these questions based upon the employee's own description of his/her job functions.

Is the employee unable to perform any of his/her job functions due to the condition: ____ No ____ Yes. ____

If so, identify the job functions the employee is unable to perform:

4. Describe other relevant medical facts, if any, related to the condition for which the employee seeks leave (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment): _____

_____

_____

_____

PART B: AMOUNT OF LEAVE NEEDED

5. Will the employee be incapacitated for a single continuous period of time due to his/her medical condition, including any time for treatment and recovery? ___No___Yes.

If so, estimate the beginning and ending dates for the period of incapacity: _____

6. Will the employee need to attend follow-up treatment appointments or work part-time or on a reduced schedule because of the employee's medical condition? ___No ___Yes.

If so, are the treatments or the reduced number of hours of work medically necessary? ___No ___Yes.

Estimate treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including any recovery period:

Estimate the part-time or reduced work schedule the employee needs, if any:

_____ hour(s) per day; _____ days per week from _____ through _____

7. Will the condition cause episodic flare-ups periodically preventing the employee from performing his/her job functions? ____NoYes ____.

Is it medically necessary for the employee to be absent from work during the flare-ups? ____ No Yes____ . If so, explain:

Based upon the patient's medical history and your knowledge of the medical condition, estimate the frequency of flare-ups and the duration of related incapacity that the patient may have over the next 6 months (e.g., 1 episode every 3 months lasting 1-2 days):

Frequency: _____ times per _____ week(s) month(s) _____

Duration: _____ hours or ___ day(s) per episode

ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER.

PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT

If submitted, it is mandatory for employers to retain a copy of this disclosure in their records for three years. 29 U.S.C. § 2616; 29 C.F.R. § 825.500.Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. The Department of Labor estimates that it will take an average of 20 minutes for respondents to complete this collection of information, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, U.S. Department of Labor, Room S-3502, 200 Constitution Ave., NW, Washington, DC 20210. **DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR; RETURN TO THE PATIENT.**

Signature of Health Care Provider

Date

Certification of Health Care Provider for Family Member's Serious Health Condition (Family and Medical Leave Act)

U.S. Department of Labor
Wage and Hour Division

OMB Control Number: 1235-0003
Expires: 5/31/2018

DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR; RETURN TO THE PATIENT.

SECTION I: For Completion by the EMPLOYER

INSTRUCTIONS to the EMPLOYER: The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA protections because of a need for leave due to a serious health condition to submit a medical certification issued by the employee's health care provider. Please complete Section I before giving this form to your employee. Your response is voluntary. While you are not required to use this form, you may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. §§ 825.306-825.308. Employers must generally maintain records and documents relating to medical certifications, recertifications, or medical histories of employees created for FMLA purposes as confidential medical records in separate files/records from the usual personnel files and in accordance with 29 C.F.R. § 1630.14(c)(1), if the Americans with Disabilities Act applies, and in accordance with 29 C.F.R. § 1635.9, if the Genetic Information Nondiscrimination Act applies.

Employer name and contact: _____

_____

SECTION II: For Completion by the EMPLOYEE

INSTRUCTIONS to the EMPLOYEE: Please complete Section II before giving this form to your medical provider. The FMLA permits an employer to require that you submit a timely, complete, and sufficient medical certification to support a request for FMLA leave due to your own serious health condition. If requested by your employer, your response is required to obtain or retain the benefit of FMLA protections. 29 U.S.C. §§ 2613, 2614(c)(3). Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA request. 29 C.F.R. § 825.313. Your employer must give you at least 15 calendar days to return this form. 29 C.F.R. §825.305(b).

Your name: _____
First Middle Last

Name of family member for whom you will provide care: _____
First Middle Last

Relationship of family member to you: _____

If family member is your son or daughter, date of birth _____

Describe care you will provide to your family member and estimate leave needed to provide care:

_____

_____

_____ _____
Employee Signature Date

SECTION III: For Completion by the HEALTH CARE PROVIDER

INSTRUCTIONS to the HEALTH CARE PROVIDER: Your patient has requested leave under the FMLA. Answer, fully and completely, all applicable parts. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can; terms such as "lifetime," "unknown," or "indeterminate" may not be sufficient to determine FMLA coverage. Limit your responses to the condition for which the employee is seeking leave. Do not provide information about genetic tests, as defined in 29 C.F.R. § 1635.3(f), genetic services, as defined in 29 C.F.R. § 1635.3(e), or the manifestation of disease or disorder in the employee's family members, 29 C.F.R. § 1635.3(b). Please be sure to sign the form on the last page.

Provider's name and business address: _____

Type of practice / Medical specialty: _____

Telephone: (_____)_____ Fax:(_____)_____

PART A: MEDICAL FACTS

1. Approximate date condition commenced: _____

Probable duration of condition: _____

Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility?
___No__Yes. If so, dates of admission: _____

Date(s) you treated the patient for condition: _____

Was medication, other than over-the-counter medication, prescribed? ___No ___Yes.

Will the patient need to have treatment visits at least twice per year due to the condition? ___No ___ Yes.

Was the patient referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)?
____No___Yes. If so, state the nature of such treatments and expected duration of treatment:

2. Is the medical condition pregnancy? ___No ___Yes. If so, expected delivery date: _____

3. Describe other relevant medical facts, if any, related to the condition for which the patient needs care (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment):

PART B: AMOUNT OF CARE NEEDED: When answering these questions, keep in mind that your patient's need for care by the employee seeking leave may include assistance with basic medical, hygienic, nutritional, safety or transportation needs, or the provision of physical or psychological care.

4. Will the employee be incapacitated for a single continuous period of time, including any time for treatment and recovery? ___No___Yes.

Estimate the beginning and ending dates for the period of incapacity: _____

During this time, will the patient need care? ___ No ____ Yes.

Explain the care needed by the patient and why such care is medically necessary: _____

_____

_____

_____

5. Will the patient require follow-up treatments, including time for recovery? ___No ___Yes.

Estimate treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including any recovery period:

Explain the care needed by the patient, and why such care is medically necessary: _____

_____

_____

6.Will the patient require care on an intermittent or reduced schedule basis, including any time for recovery?

__No __ Yes.

Estimate the hours the patient needs care on an intermittent basis, if any:

_____ hour(s) per day; _____ days per week from _____ through _____

Explain the care needed by the patient, and why such care is medically necessary:_____

_____

_____

_____

_____

7. Will the condition cause episodic flare-ups periodically preventing the patient from participating in normal daily activities? _____ No _____ Yes

Based on the patient's medical history and your knowledge of the medical condition, estimate the frequency of flare-ups and the duration of related incapacity that the patient may have over the next 6 months (e.g. 1 episode every 3 months lasting 1-2 days):

Frequency _____ times per ____ week(s) _____month(s)

Duration: _____ hours or ____ day(s) per episode

Does the patient need care during these flare-ups? ___ No ___ Yes

Explain the care needed by the patient, and why such care is medically necessary: _____

_____

_____

ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER.

_____

Signature of Health Care Provider Date

PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT

If submitted, it is mandatory for employers to retain a copy of this disclosure in their records for three years. 29 U.S.C. § 2616; 29 C.F.R. § 825.500.Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. The Department of Labor estimates that it will take an average of 20 minutes for respondents to complete this collection of information, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, U.S. Department of Labor, Room S-3502, 200 Constitution Ave., NW, Washington, DC 20210. **DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR; RETURN TO THE PATIENT.**

Certification for Serious Injury or Illness of a Veteran for Military Caregiver Leave (Family and Medical Leave Act)

U.S. Department of Labor
Wage and Hour Division

OMB Control Number: 1235-0003
Expires: 5/31/2018

Notice to the EMPLOYER

The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking military caregiver leave under the FMLA leave due to a serious injury or illness of a covered veteran to submit a certification providing sufficient facts to support the request for leave. Your response is voluntary. While you are not required to use this form, you may not ask the employee to provide more information than allowed under the FMLA regulations, 29 CFR 825.310. Employers must generally maintain records and documents relating to medical certifications, recertifications, or medical histories of employees or employees' family members, created for FMLA purposes as confidential medical records in separate files/records from the usual personnel files and in accordance with 29 CFR 1630.14(c)(1), if the Americans with Disabilities Act applies, and in accordance with 29 CFR 1635.9, if the Genetic Information Nondiscrimination Act applies.

SECTION I: For completion by the EMPLOYEE and/or the VETERAN for whom the employee is requesting leave

INSTRUCTIONS to the EMPLOYEE and/or VETERAN: Please complete Section I before having Section II completed. The FMLA permits an employer to require that an employee submit a timely, complete, and sufficient certification to support a request for military caregiver leave under the FMLA leave due to a serious injury or illness of a covered veteran. If requested by the employer, your response is required to obtain or retain the benefit of FMLA-protected leave. 29 U.S.C. 2613, 2614(c)(3). Failure to do so may result in a denial of an employee's FMLA request. 29 CFR 825.310(f). The employer must give an employee at least 15 calendar days to return this form to the employer.

(This section must be completed before Section II can be completed by a health care provider.)

Part A: EMPLOYEE INFORMATION

Name and address of employer (this is the employer of the employee requesting leave to care for a veteran):

_____

Name of employee requesting leave to care for a veteran:

_____

First Middle Last

Name of veteran (for whom employee is requesting leave):

_____

First Middle Last

Relationship of employee to veteran:

Spouse☐ Parent☐ Son☐ Daughter☐ Next of Kin ☐ (please specify relationship):

Part B: VETERAN INFORMATION

(1) Date of the veteran's discharge:

_____

(2) Was the veteran **dishonorably** discharged or released from the Armed Forces (including the National Guard or Reserves)? Yes☐ No☐

(3) Please provide the veteran's military branch, rank and unit at the time of discharge:

_____

(4) Is the veteran receiving medical treatment, recuperation, or therapy for an injury or illness? Yes☐ No☐

Part C: CARE TO BE PROVIDED TO THE VETERAN

Describe the care to be provided to the veteran and an estimate of the leave needed to provide the care:

_____

_____

SECTION II: For completion by: (1) a United States Department of Defense ("DOD") health care provider; (2) a United States Department of Veterans Affairs ("VA") health care provider; (3) a DOD TRICARE network authorized private health care provider; (4) a DOD non-network TRICARE authorized private health care provider; or (5) a health care provider as defined in 29 CFR 825.125.

INSTRUCTIONS to the HEALTH CARE PROVIDER: The employee named in Section I has requested leave under the military caregiver leave provision of the FMLA to care for a family member who is a veteran. For purposes of FMLA military caregiver leave, a serious injury or illness means an injury or illness incurred by the servicemember in the line of duty on active duty in the Armed Forces (or that existed before the beginning of the servicemember's active duty and was aggravated by service in the line of duty on active duty in the Armed Forces) and manifested itself before or after the servicemember became a veteran, and is:

(i) a continuation of a serious injury or illness that was incurred or aggravated when the covered veteran was a member of the Armed Forces and rendered the servicemember unable to perform the duties of the servicemember's office, grade, rank, or rating; or
(ii) a physical or mental condition for which the covered veteran has received a U.S. Department of Veterans Affairs Service Related Disability Rating (VASRD) of 50 percent or greater, and such VASRD rating is based, in whole or in part, on the condition precipitating the need for military caregiver leave; or
(iii) a physical or mental condition that substantially impairs the covered veteran's ability to secure or follow a substantially gainful occupation by reason of a disability or disabilities related to military service, or would do so absent treatment; or
(iv) an injury, including a psychological injury, on the basis of which the covered veteran has been enrolled in the Department of Veterans' Affairs Program of Comprehensive Assistance for Family Caregivers.

A complete and sufficient certification to support a request for FMLA military caregiver leave due to a covered veteran's serious injury or illness includes written documentation confirming that the veteran's injury or illness was incurred in the line of duty on active duty or existed before the beginning of the veteran's active duty and was aggravated by service in the line of duty on active duty, and that the veteran is undergoing treatment, recuperation, or therapy for such injury or illness by a health care provider listed above. Answer fully and completely all applicable parts. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can; terms such as "lifetime," "unknown," or "indeterminate" may not be sufficient to determine FMLA military caregiver leave coverage. Limit your responses to the veteran's condition for which the employee is seeking leave. Do not provide information about genetic tests, as defined in 29 CFR 1635.3(f), or genetic services, as defined in 29 CFR 1635.3(e).

(Please ensure that Section I has been completed before completing this section. Please be sure to sign the form on the last page and return this form to the employee requesting leave (See Section I, Part A above). **DO NOT SEND THE COMPLETED FORM TO THE WAGE AND HOUR DIVISION.**)

Part A: HEALTH CARE PROVIDER INFORMATION

Health care provider's name and business address:

_____

Telephone: ( ) _____ Fax: ( ) _____ Email: _____

Type of Practice/Medical Specialty: _____

Please indicate if you are:

☐ a DOD health care provider

☐ a VA health care provider

☐ a DOD TRICARE network authorized private health care provider

☐ a DOD non-network TRICARE authorized private health care provider

☐ other health care provider

PART B: MEDICAL STATUS

Note: If you are unable to make certain of the military-related determinations contained in Part B, you are permitted to rely upon determinations from an authorized DOD representative (such as, DOD Recovery Care Coordinator) or an authorized VA representative.

(1) The Veteran's medical condition is:

☐ A continuation of a serious injury or illness that was incurred or aggravated when the covered veteran was a member of the Armed Forces and rendered the servicemember unable to perform the duties of the servicemember's office, grade, rank, or rating.

☐ A physical or mental condition for which the covered veteran has received a U.S. Department of Veterans Affairs Service Related Disability Rating (VASRD) of 50% or higher, and such VASRD rating is based, in whole or in part, on the condition precipitating the need for military caregiver leave.

☐ A physical or mental condition that substantially impairs the covered veteran's ability to secure or follow a substantially gainful occupation by reason of a disability or disabilities related to military service, or would do so absent treatment.

☐ An injury, including a psychological injury, on the basis of which the covered veteran is enrolled in the Department of Veterans' Affairs Program of Comprehensive Assistance for Family Caregivers.

☐ None of the above.

(2) Is the veteran being treated for a condition which was incurred or aggravated by service in the line of duty on active duty in the Armed Forces? Yes☐ No☐

(3) Approximate date condition commenced: _____

(4) Probable duration of condition and/or need for care: _____

(5) Is the veteran undergoing medical treatment, recuperation, or therapy for this condition? Yes☐ No☐

If yes, please describe medical treatment, recuperation or therapy:

_____

PART C: VETERAN'S NEED FOR CARE BY FAMILY MEMBER

"Need for care" encompasses both physical and psychological care. It includes situations where, for example, due to his or her serious injury or illness, the veteran is unable to care for his or her own basic medical, hygienic, or nutritional needs or safety, or is unable to transport him or herself to the doctor. It also includes providing psychological comfort and reassurance which would be beneficial to the veteran who is receiving inpatient or home care.

(1) Will the veteran need care for a single continuous period of time, including any time for treatment and recovery? Yes☐ No☐

If yes, estimate the beginning and ending dates for this period of time: _____

(2) Will the veteran require periodic follow-up treatment appointments? Yes☐ No☐

If yes, estimate the treatment schedule: _____

(3) Is there a medical necessity for the veteran to have periodic care for these follow-up treatment appointments? Yes☐ No☐

(4) Is there a medical necessity for the veteran to have periodic care for other than scheduled follow-up treatment appointments (e.g., episodic flare-ups of medical condition)? Yes☐ No☐

If yes, please estimate the frequency and duration of the periodic care:

_____

_____

Signature of Health Care Provider: _____ Date: _____

PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT

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Certification of Qualifying Exigency For Military Family Leave (Family and Medical Leave Act)

U.S. Department of Labor

Wage and Hour Division

OMB Control Number: 1235-0003
Expires: 5/31/2018

SECTION I: For Completion by the EMPLOYER

INSTRUCTIONS to the EMPLOYER: The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA leave due to a qualifying exigency to submit a certification. Please complete Section I before giving this form to your employee. Your response is voluntary, and while you are not required to use this form, you may not ask the employee to provide more information than allowed under the FMLA regulations, 29 CFR 825.309.

Employer name: _____

Contact Information: _____

SECTION II: For Completion by the EMPLOYEE

INSTRUCTIONS to the EMPLOYEE: Please complete Section II fully and completely. The FMLA permits an employer to require that you submit a timely, complete, and sufficient certification to support a request for FMLA leave due to a qualifying exigency. Several questions in this section seek a response as to the frequency or duration of the qualifying exigency. Be as specific as you can; terms such as "unknown," or "indeterminate" may not be sufficient to determine FMLA coverage. Your response is required to obtain a benefit. 29 CFR 825.310. While you are not required to provide this information, failure to do so may result in a denial of your request for FMLA leave. Your employer must give you at least 15 calendar days to return this form to your employer.

Your Name: _____
First Middle Last

Name of military member on covered active duty or call to covered active duty status:

_____
First Middle Last

Relationship of military member to you: _____

Period of military member's covered active duty: _____

A complete and sufficient certification to support a request for FMLA leave due to a qualifying exigency includes written documentation confirming a military member's covered active duty or call to covered active duty status. Please check one of the following and attach the indicated document to support that the military member is on covered active duty or call to covered active duty status.

☐ A copy of the military member's covered active duty orders is attached.

☐ Other documentation from the military certifying that the military member is on covered active duty (or has been notified of an impending call to covered active duty) is attached.

☐ I have previously provided my employer with sufficient written documentation confirming the military member's covered active duty or call to covered active duty status.

PART A: QUALIFYING REASON FOR LEAVE

1. Describe the reason you are requesting FMLA leave due to a qualifying exigency (including the specific reason you are requesting leave):

_____

_____

_____

_____

2. A complete and sufficient certification to support a request for FMLA leave due to a qualifying exigency includes any available written documentation which supports the need for leave; such documentation may include a copy of a meeting announcement for informational briefings sponsored by the military; a document confirming the military member's Rest and Recuperation leave; a document confirming an appointment with a third party, such as a counselor or school official, or staff at a care facility; or a copy of a bill for services for the handling of legal or financial affairs. Available written documentation supporting this request for leave is attached.

Yes ☐ No ☐ None Available ☐

PART B: AMOUNT OF LEAVE NEEDED

1. Approximate date exigency commenced: _____

Probable duration of exigency: _____

2. Will you need to be absent from work for a single continuous period of time due to the qualifying exigency?

Yes☐ No☐

If so, estimate the beginning and ending dates for the period of absence:

_____

3. Will you need to be absent from work periodically to address this qualifying exigency? Yes☐ No☐

Estimate schedule of leave, including the dates of any scheduled meetings or appointments:

_____

_____

_____

Estimate the frequency and duration of each appointment, meeting, or leave event, including any travel time (i.e., 1 deployment-related meeting every month lasting 4 hours):

Frequency: _____ times per _____ week(s) _____ month(s)

Duration: _____ hours ___ day(s) per event.

PART C:

If leave is requested to meet with a third party (such as to arrange for childcare or parental care, to attend counseling, to attend meetings with school, childcare or parental care providers, to make financial or legal arrangements, to act as the military member's representative before a federal, state, or local agency for purposes of obtaining, arranging or appealing military service benefits, or to attend any event sponsored by the military or military service organizations), a complete and sufficient certification includes the name, address, and appropriate contact information of the individual or entity with whom you are meeting (i.e., either the telephone or fax number or email address of the individual or entity). This information may be used by your employer to verify that the information contained on this form is accurate.

Name of Individual: _____ Title: _____

Organization: _____

Address: _____

Telephone: (_____) _____ Fax: (_____) _____

Email: _____

Describe nature of meeting: _____

_____

_____

_____

_____

_____

_____

_____

PART D:

I certify that the information I provided above is true and correct.

Signature of Employee _____ Date _____

PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT

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Certification for Serious Injury or Illness of a Veteran for Military Caregiver Leave (Family and Medical Leave Act)

U.S. Department of Labor

Wage and Hour Division

OMB C U.S. Wage and Hour Division)03
Expires: 5/31/2018

Notice to the EMPLOYER

INSTRUCTIONS to the EMPLOYER: The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA leave due to a serious injury or illness of a current servicemember to submit a certification providing sufficient facts to support the request for leave. Your response is voluntary. While you are not required to use this form, you may not ask the employee to provide more information than allowed under the FMLA regulations, 29 CFR 825.310. Employers must generally maintain records and documents relating to medical certifications, recertifications, or medical histories of employees or employees' family members created for FMLA purposes as confidential medical records in separate files/records from the usual personnel files and in accordance with 29 CFR 1630.14(c)(1), if the Americans with Disabilities Act applies, and in accordance with 29 CFR 1635.9, if the Genetic Information Nondiscrimination Act applies.

SECTION I: For Completion by the EMPLOYEE and/or the CURRENT SERVICEMEMBER for whom the Employee Is Requesting Leave

INSTRUCTIONS to the EMPLOYEE or CURRENT SERVICEMEMBER: Please complete Section I before having Section II completed. The FMLA permits an employer to require that an employee submit a timely, complete, and sufficient certification to support a request for FMLA leave due to a serious injury or illness of a servicemember. If requested by the employer, your response is required to obtain or retain the benefit of FMLA-protected leave. 29 U.S.C. 2613, 2614(c)(3). Failure to do so may result in a denial of an employee's FMLA request. 29 CFR 825.310(f). The employer must give an employee at least 15 calendar days to return this form to the employer.

SECTION II: For Completion by a UNITED STATES DEPARTMENT OF DEFENSE ("DOD") HEALTH CARE PROVIDER or a HEALTH CARE PROVIDER who is either: (1) a United States Department of Veterans Affairs ("VA") health care provider; (2) a DOD TRICARE network authorized private health care provider; (3) a DOD non-network TRICARE authorized private health care provider; or (4) a health care provider as defined in 29 CFR 825.125

INSTRUCTIONS to the HEALTH CARE PROVIDER: The employee listed on Page 2 has requested leave under the FMLA to care for a family member who is a current member of the Regular Armed Forces, the National Guard, or the Reserves who is undergoing medical treatment, recuperation, or therapy, is otherwise in outpatient status, or is otherwise on the temporary disability retired list for a serious injury or illness. For purposes of FMLA leave, a serious injury or illness is one that was incurred in the line of duty on active duty in the Armed Forces or that existed before the beginning of the member's active duty and was aggravated by service in the line of duty on active duty in the Armed Forces that may render the servicemember medically unfit to perform the duties of his or her office, grade, rank, or rating.

A complete and sufficient certification to support a request for FMLA leave due to a current servicemember's serious injury or illness includes written documentation confirming that the servicemember's injury or illness was incurred in the line of duty on active duty or if not, that the current servicemember's injury or illness existed before the beginning of the servicemember's active duty and was aggravated by service in the line of duty on active duty in the Armed Forces, and that the current servicemember is undergoing treatment for such injury or illness by a health care provider listed above. Answer, fully and completely, all applicable parts. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can; terms such as "lifetime," "unknown," or "indeterminate" may not be sufficient to determine FMLA coverage. Limit your responses to the servicemember's condition for which the employee is seeking leave. Do not provide information about genetic tests, as defined in 29 CFR 1635.3(f), or genetic services, as defined in 29 CFR 1635.3(e).

SECTION I: For Completion by the EMPLOYEE and/or the CURRENT SERVICEMEMBER for whom the Employee Is Requesting Leave:

(This section must be completed first before any of the below sections can be completed by a health care provider.)

Part A: EMPLOYEE INFORMATION
Name and Address of Employer (this is the employer of the employee requesting leave to care for the current servicemember):

_____

Name of Employee Requesting Leave to Care for the Current Servicemember:

_____
First Middle Last

Name of the Current Servicemember (for whom employee is requesting leave to care):

_____
First Middle Last

Relationship of Employee to the Current Servicemember:

Spouse☐ Parent ☐ Son ☐ Daughter ☐ Next of Kin ☐

Part B: SERVICEMEMBER INFORMATION

(1) Is the Servicemember a Current Member of the Regular Armed Forces, the National Guard or Reserves?
Yes☐ No☐

If yes, please provide the servicemember's military branch, rank and unit currently assigned to:

_____

Is the servicemember assigned to a military medical treatment facility as an outpatient or to a unit established for the purpose of providing command and control of members of the Armed Forces receiving medical care as outpatients (such as a medical hold or warrior transition unit)?
Yes☐ No☐

If yes, please provide the name of the medical treatment facility or unit:

_____

(2) Is the Servicemember on the Temporary Disability Retired List (TDRL)?
Yes☐ No☐

Part C: CARE TO BE PROVIDED TO THE SERVICEMEMBER

Describe the Care to Be Provided to the Current Servicemember and an Estimate of the Leave Needed to Provide the Care:

_____

_____

SECTION II: For Completion by a United States Department of Defense ("DOD") Health Care Provider or a Health Care Provider who is either: (1) a United States Department of Veterans Affairs ("VA") health care provider; (2) a DOD TRICARE network authorized private health care provider; (3) a DOD non-network TRICARE authorized private health care provider; or (4) a health care provider as defined in 29 CFR 825.125

If you are unable to make certain of the military-related determinations contained below in Part B, you are permitted to rely upon determinations from an authorized DOD representative (such as a DOD recovery care coordinator).

(Please ensure that Section I above has been completed before completing this section. Please be sure to sign the form on the last page.)

Part A: HEALTH CARE PROVIDER INFORMATION

Health Care Provider's Name and Business Address:

_____

Type of Practice/Medical Specialty: _____

Please state whether you are either: (1) a DOD health care provider; (2) a VA health care provider; (3) a DOD TRICARE network authorized private health care provider; (4) a DOD non-network TRICARE authorized private health care provider, or (5) a health care provider as defined in 29 CFR 825.125:

_____

Telephone: ( ) _____ Fax: ( ) _____ Email: _____

PART B: MEDICAL STATUS

(1) The current Servicemember's medical condition is classified as (Check One of the Appropriate Boxes):

☐ **(VSI) Very Seriously Ill/Injured** – Illness/Injury is of such a severity that life is imminently endangered. Family members are requested at bedside immediately. (Please note this is an internal DOD casualty assistance designation used by DOD healthcare providers.)

☐ **(SI) Seriously Ill/Injured** – Illness/injury is of such severity that there is cause for immediate concern, but there is no imminent danger to life. Family members are requested at bedside. (Please note this is an internal DOD casualty assistance designation used by DOD healthcare providers.)

☐ **OTHER Ill/Injured** – a serious injury or illness that may render the servicemember medically unfit to perform the duties of the member's office, grade, rank, or rating.

☐ **NONE OF THE ABOVE** (Note to Employee: If this box is checked, you may still be eligible to take leave to care for a covered family member with a "serious health condition" under § 825.113 of the FMLA. If such leave is requested, you may be required to complete DOL FORM WH-380-F or an employer-provided form seeking the same information.)

(2) Is the current Servicemember being treated for a condition which was incurred or aggravated by service in the line of duty on active duty in the Armed Forces? Yes☐ No☐

(3) Approximate date condition commenced: _____

(4) Probable duration of condition and/or need for care: _____

(5) Is the servicemember undergoing medical treatment, recuperation, or therapy for this condition? Yes ☐ No ☐

If yes, please describe medical treatment, recuperation or therapy:

_____

PART C: SERVICEMEMBER'S NEED FOR CARE BY FAMILY MEMBER

(1) Will the servicemember need care for a single continuous period of time, including any time for treatment and recovery? Yes☐ No☐

If yes, estimate the beginning and ending dates for this period of time: _____

(2) Will the servicemember require periodic follow-up treatment appointments? Yes☐ No☐

If yes, estimate the treatment schedule: _____

(3) Is there a medical necessity for the servicemember to have periodic care for these follow-up treatment appointments? Yes☐ No☐

(4) Is there a medical necessity for the servicemember to have periodic care for other than scheduled follow-up treatment appointments (e.g., episodic flare-ups of medical condition)?
Yes☐ No☐

If yes, please estimate the frequency and duration of the periodic care:

_____

_____

Signature of Health Care Provider: _____ Date: _____

PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT

If submitted, it is mandatory for employers to retain a copy of this disclosure in their records for three years, in accordance with 29 U.S.C. 2616; 29 CFR 825.500. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. The Department of Labor estimates that it will take an average of 20 minutes for respondents to complete this collection of information, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, U.S. Department of Labor, Room S-3502, 200 Constitution AV, NW, Washington, DC 20210. **DO NOT SEND THE COMPLETED FORM TO THE WAGE AND HOUR DIVISION; RETURN IT TO THE PATIENT.**

Notice of Eligibility and Rights & Responsibilities (Family and Medical Leave Act)

U.S. Department of Labor

Wage and Hour Division

OMB Control Number: 1235-0003
Expires: 5/31/2018

In general, to be eligible an employee must have worked for an employer for at least 12 months, meet the hours of service requirement in the 12 months preceding the leave, and work at a site with at least 50 employees within 75 miles. While use of this form by employers is optional, a fully completed Form WH-381 provides employees with the information required by 29 C.F.R. § 825.300(b), which must be provided within five business days of the employee notifying the employer of the need for FMLA leave. Part B provides employees with information regarding their rights and responsibilities for taking FMLA leave, as required by 29 C.F.R. § 825.300(b), (c)**.**

[Part A – NOTICE OF ELIGIBILITY]

TO: _____
Employee

FROM: _____
Employer Representative

DATE: _____

On _____, _____you informed us that you needed leave beginning on for:

_____ The birth of a child, or placement of a child with you for adoption or foster care;

_____ Your own serious health condition;

_____ Because you are needed to care for your ____ spouse; _____child; _____ parent due to his/her serious health condition.

_____ Because of a qualifying exigency arising out of the fact that your ____ spouse; _____son or daughter; _____ parent is on covered active duty or call to covered active duty status with the Armed Forces.

_____ Because you are the ____ spouse; _____son or daughter; _____ parent; _____ next of kin of a covered servicemember with a serious injury or illness.

This Notice is to inform you that you:

_____ Are eligible for FMLA leave (See Part B below for Rights and Responsibilities)

_____ Are **not** eligible for FMLA leave, because (only one reason need be checked, although you may not be eligible for other reasons):

_____ You have not met the FMLA's 12-month length of service requirement. As of the first date of requested leave, you will have worked approximately ___ months towards this requirement

_____ You have not met the FMLA's hours of service requirement.

_____ You do not work and/or report to a site with 50 or more employees within 75-miles.

If you have any questions, contact _____ or view the FMLA poster located in _____**.**

[PART B-RIGHTS AND RESPONSIBILITIES FOR TAKING FMLA LEAVE]

As explained in Part A, you meet the eligibility requirements for taking FMLA leave and still have FMLA leave available in the applicable 12-month period. **However, in order for us to determine whether your absence qualifies as FMLA leave, you must return the following information to us by _____.** (If a certification is requested, employers must allow at least 15 calendar days from receipt of this notice; additional time may be required in some circumstances.) If sufficient information is not provided in a timely manner, your leave may be denied.

____ Sufficient certification to support your request for FMLA leave. A certification form that sets forth the information necessary to support your request ____**is/**____ **is not** enclosed.

____ Sufficient documentation to establish the required relationship between you and your family member.

____ Other information needed (such as documentation for military family leave): _____

____ No additional information requested

If your leave does qualify as FMLA leave you will have the following **responsibilities** while on FMLA leave (only checked blanks apply):

____ Contact _____ at _____ to make arrangements to continue to make your share of the premium payments on your health insurance to maintain health benefits while you are on leave. You have a minimum 30-day (or, indicate longer period, if applicable) grace period in which to make premium payments. If payment is not made timely, your group health insurance may be cancelled, provided we notify you in writing at least 15 days before the date that your health coverage will laps

____ You will be required to use your available paid _____ **sick**, _____ **vacation**, and/or _____**other leave** during your FMLA absence. This means that you will receive your paid leave and the leave will also be considered protected FMLA leave and counted against your FMLA leave entitlement.

____ Due to your status within the company, you are considered a "key employee" as defined in the FMLA. As a "key employee," restoration to employment may be denied following FMLA leave on the grounds that such restoration will cause substantial and grievous economic injury to us. We ___**have**/____ **have not** determined that restoring you to employment at the conclusion of FMLA leave will cause substantial and grievous economic harm to us.

____ While on leave you will be required to furnish us with periodic reports of your status and intent to return to work every _____. (Indicate interval of periodic reports, as appropriate for the particular leave situation).

If the circumstances of your leave change, and you are able to return to work earlier than the date indicated on the this form, you will be required to notify us at least two workdays prior to the date you intend to report for work.

If your leave does qualify as FMLA leave you will have the following **rights** while on FMLA leave:

- You have a right under the FMLA for up to 12 weeks of unpaid leave in a 12-month period calculated as:
  _____ the calendar year (January – December).
  _____ a fixed leave year based on _____.
  _____ the 12-month period measured forward from the date of your first FMLA leave usage.
  _____ a "rolling" 12-month period measured backward from the date of any FMLA leave usage.

- You have a right under the FMLA for up to 26 weeks of unpaid leave in a single 12-month period to care for a covered servicemember with a serious injury or illness. This single 12-month period commenced on _____.
- Your health benefits must be maintained during any period of unpaid leave under the same conditions as if you continued to work.
- You must be reinstated to the same or an equivalent job with the same pay, benefits, and terms and conditions of employment on your return from FMLA-protected leave. (If your leave extends beyond the end of your FMLA entitlement, you do not have return rights under FMLA.)
- If you do not return to work following FMLA leave for a reason other than: 1) the continuation, recurrence, or onset of a serious health condition which would entitle you to FMLA leave; 2) the continuation, recurrence, or onset of a covered servicemember's serious injury or illness which would entitle you to FMLA leave; or 3) other circumstances beyond your control, you may be required to reimburse us for our share of health insurance premiums paid on your behalf during your FMLA leave.
- If we have not informed you above that you must use accrued paid leave while taking your unpaid FMLA leave entitlement, you have the right to have **____ sick, ____vacation,** and/or **___ other leave** run concurrently with your unpaid leave entitlement, provided you meet any applicable requirements of the leave policy. Applicable conditions related to the substitution of paid leave are referenced or set forth below. If you do not meet the requirements for taking paid leave, you remain entitled to take unpaid FMLA leave.

  ~~___For a copy of conditions applicable to sick/vacation/other leave usage please refer to _____ available at: _____.~~

  ____Applicable conditions for use of paid leave:_____

Once we obtain the information from you as specified above, we will inform you, within 5 business days, whether your leave will be designated as FMLA leave and count towards your FMLA leave entitlement. If you have any questions, please do not hesitate to contact:
_____at _____.

PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT

It is mandatory for employers to provide employees with notice of their eligibility for FMLA protection and their rights and responsibilities. 29 U.S.C. § 2617; 29 C.F.R. § 825.300(b), (c). It is mandatory for employers to retain a copy of this disclosure in their records for three years. 29 U.S.C. § 2616; 29 C.F.R. § 825.500. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. The Department of Labor estimates that it will take an average of 10 minutes for respondents to complete this collection of information, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, U.S. Department of Labor, Room S-3502, 200 Constitution Ave., NW, Washington, DC 20210. **DO NOT SEND THE COMPLETED FORM TO THE WAGE AND HOUR DIVISION.**

Designation Notice (Family and Medical Leave Act)

U.S. Department of Labor
Wage and Hour Division

U.S. Wage and Hour Division

OMB Control Number: 1235-0003
Expires: 5/31/2018

Leave covered under the Family and Medical Leave Act (FMLA) must be designated as FMLA-protected and the employer must inform the employee of the amount of leave that will be counted against the employee's FMLA leave entitlement. In order to determine whether leave is covered under the FMLA, the employer may request that the leave be supported by a certification. If the certification is incomplete or insufficient, the employer must state in writing what additional information is necessary to make the certification complete and sufficient. While use of this form by employers is optional, a fully completed Form H-382 provides an easy method of providing employees with the written information required by 29 C.F.R. §§ 825.300(c), 825.301, and 825.305(c).

To: _____

Date: _____

We have reviewed your request for leave under the FMLA and any supporting documentation that you have provided. We received your most recent information on_____ and decided:

_____ Your FMLA leave request is approved. All leave taken for this reason will be designated as FMLA leave.

The FMLA requires that you notify us as soon as practicable if dates of scheduled leave change or are extended, or were initially unknown. Based on the information you have provided to date, we are providing the following information about the amount of time that will be counted against your leave entitlement:

_____ Provided there is no deviation from your anticipated leave schedule, the following number of hours, days, or weeks will be counted against your leave entitlement: _____

_____ Because the leave you will need will be unscheduled, it is not possible to provide the hours, days, or weeks that will be counted against your FMLA entitlement at this time. You have the right to request this information once in a 30-day period (if leave was taken in the 30-day period).

Please be advised (check if applicable):

_____ You have requested to use paid leave during your FMLA leave. Any paid leave taken for this reason will count against your FMLA leave entitlement.

_____ We are requiring you to substitute or use paid leave during your FMLA leave.

_____You will be required to present a fitness-for-duty certificate to be restored to employment. If such certification is not timely received, your return to work may be delayed until certification is provided. A list of the essential functions of your position ___ **is** ___ **is not** attached. If attached, the fitness-for-duty certification must address your ability to perform these functions.

_____ Additional information is needed to determine if your FMLA leave request can be approved:

_____ The certification you have provided is not complete and sufficient to determine whether the FMLA applies to your leave request. You must provide the following information no later than _____, unless it is
(Provide at least seven calendar days)
not practicable under the particular circumstances despite your diligent good faith efforts, or your leave may be denied.

_____
(Specify information needed to make the certification complete and sufficient)

_____

_____ We are exercising our right to have you obtain a second or third opinion medical certification at our expense, and we will provide further details at a later time.

_____ Your FMLA Leave request is Not Approved.
_____ The FMLA does not apply to your leave request.
____ You have exhausted your FMLA leave entitlement in the applicable 12-month period.

PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT

It is mandatory for employers to inform employees in writing whether leave requested under the FMLA has been determined to be covered under the FMLA. 29 U.S.C. § 2617; 29 C.F.R. §§ 825.300(d), (e). It is mandatory for employers to retain a copy of this disclosure in their records for three years. 29 U.S.C. § 2616; 29 C.F.R. §825.500. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. The Department of Labor estimates that it will take an average of 10 – 30 minutes for respondents to complete this collection of information, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, U.S. Department of Labor, Room S-3502, 200 Constitution Ave., NW, Washington, DC 20210. **DO NOT SEND THE COMPLETED FORM TO THE WAGE AND HOUR DIVISION.**

HIPAA Privacy Authorization Form

** Authorization for Use or Disclosure of Protected Health Information

(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164) **

** 1. Authorization **

I authorize_____(healthcare provider) to use and disclose the protected health information described below to _____(individual seeking the information).

2. Effective Period

This authorization for release of information covers the period of healthcare from:

a. ☐ _____ to _____.

**OR **

b. ☐ all past, present and future periods.

3. Extent of Authorization

a. ☐ I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol and drug abuse).

OR

b. ☐ I authorize the release of my complete health record with the exception of the following information:

☐ Mental health records

☐ Communicable diseases (including HIV and AIDS)

☐ Alcohol/drug abuse treatment

☐ Other (please specify)_____

4. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

5. This authorization shall be in force and effect until _____(date or event), at which time this authorization expires.

6. I understand that I have the right to revoke this authorization, in writing at any time. I understand that revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

7. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

8. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Signature of patient or personal representative

Printed name of patient or personal representative and his or her relationship to patient

---

Date

Date

Dr. _____

Dear Dr. _____ :

_____ is a patient of yours and also an employee of _____County _____. At this point, we are attempting to determine if _____ is fit for duty. Therefore, I am enclosing a signed medical authorization that will allow you to provide our agency information regarding her medical status. I am requesting that you provide an opinion as to whether this employee is able to perform the essential functions of the job with or without an accommodation. For your review, I have enclosed a description of the employee's job duties.

Specifically, I would ask that you answer the following questions:

1. Does this employee have a physical or mental impairment and/or disability?
2. If she has such impairment, please describe it.
3. To what extent does this disability affect the employee's daily life activities?
4. Can this employee perform the functions of her position?
5. If the employee cannot perform the functions of her position, are there any accommodations that you can suggest?
6. Is there any risk to the employee by her being in the workplace?

<u>Genetic Information Nondiscrimiation Act of 2008 Disclaimer</u>
The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of an individual, except as specifically allowed by this law. To comply with this law we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic Information" as defined by GINA includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Your prompt attention to this matter is appreciated. If there are any costs associated with this report, please bill our agency at the above address. If you have any questions concerning this matter, please feel free to contact me.

Sincerely,

SAMPLE DOCTOR LETTER – FITNESS FOR DUTY

Re: Fitness for duty

Dear Dr._____:

Enclosed is a signed medical authorization from _____ . At this point, we are attempting to determine if_____ is fit for duty. I have enclosed a copy of her job description. Please respond to the following questions.

1. Does _____ have a physical or mental impairment?

2. If she has such impairment, please describe it.

3. Please explain how the impairment may limit_____ in her activities.

4. Is _____ fit for duty in her current position?

5. Can you suggest any accommodations for _____?

6. Does _____ presence in the workplace present a risk to herself or others?

Your prompt attention to this matter is appreciated. If you have any questions concerning this matter, please feel free to contact me.

Sincerely

MEDICAL AND HOSPITAL AUTHORIZATION SAMPLE LETTER

TO:

MEDICAL AND HOSPITAL AUTHORIZATION

This will authorize you to release to _____, any and all information relating to my fitness for duty, including any records pertaining to my treatment for _____ and allow them to copy and photocopy any records which you may have regarding my condition, when under your observation or treatment including, but not limited to, my medical chart, history, x-ray readings and findings, diagnosis, and reports from the physicians, therapists, prognosis, and subsequently any future developments. This document als3o authorizes you to discuss my medical history, current medical status and prognosis with representatives of _____ and to fully respond to any questions they may have. This authorization shall stand until you receive written revocation thereof.

_____ _____

Employee Date

_____ _____

Witness Date

Section VI

General HR Stuff

SAMPLE HOURS REDUCTION AGREEMENT

By signing this document I indicate my agreement to voluntarily reduce my hours of work from _____hours per week to____ hours per week. I agree not to work more than _____hours per week without prior authorization of my supervisor, except in an emergency situation.

I understand that this will result in a proportional reduction in pay; as well as a reduction in the accumulation of those benefits, e.g., sick leave and vacation leave, that are based on my hours of work.

I agree that my hours may be increased as needed, but that I will regularly be assigned to work _____hours per week. I further understand that even if I am authorized or assigned to work more than hours per week, I am not entitled to time and one-half compensation unless and until I work more than forty (40) hours in a workweek in accordance with the County's current policy for overtime compensation.

I recognize that the County may increase (or return) my work hours to ____ hours per week with at least fourteen days notice.

_____

Employee Signature Date

_____

Print name

Accepted:

_____

Appointing Authority Representatives

CERTIFIED MAIL [Date]

RETURN RECEIPT REQUESTED

Re: Family Medical Leave

Dear Employee :

On **[date],** you advised us that you were requesting a leave of absence that may qualify as family medical leave under the law. We understand you may be claiming to have a serious health condition which prevents you from performing an essential function of your position **[Or insert other FMLA covered reason for leave]**. On behalf of **[the employer]**, I wish to extend you our support as well as stress how important it is for you and **[the employer**] to communicate throughout this process.

All leave will be counted against your annual family medical leave entitlement. Under our policy, a leave of absence that qualifies as FMLA under state or federal law run concurrently with other types of paid or unpaid leave, if any. Your FMLA leave, **[number of days/hours]**, has been provisionally granted as of the date of this letter pending receipt certification from a health care provider as outlined below.

You must have your health care provider complete the enclosed "Certification of Health Care Provider" form and you must return this completed form within 15 calendar days of its receipt. If you fail to complete and return these forms in a timely manner, your leave can be delayed until it is provided. In addition, the failure to submit the completed medical certification form in a timely manner may result in absences being considered unexcused in accordance with our absenteeism policy.

Please note, your completion of other forms, such as workers' compensation forms, or the previous submission of a note from a health care provider is inadequate. YOU MUST COMPLETE AND RETURN THE ENCLOSED CERTIFICATION OF HEALTH CARE PROVIDER FORM.

If you have any questions regarding the leave policies or the content of this letter, please do not hesitate to contact me.

Sincerely,

Enclosures
(Notice of Eligibility and Rights Form WH-381, Designation Form WH-382 & Responsibilities Form; Medical Certification Form WH-382)

NOTICE OF POLICY CHANGE

To: **All Employees**
From:
Date:
Re: **Medical Marijuana & The Drug-Free Workplace Policy**

On June 8, 2016, Ohio Sub HB 523 was enacted, which authorizes certain health providers to prescribe limited types of medicinal marijuana to qualifying patients. Ohio's medical marijuana law that takes effect on September 8, 2016. This [County] has established and maintains a Drug-Free Workplace Policy that is unaffected by the Ohio Sub HB 523 or Ohio's medical marijuana law taking effect.

This County has a zero-tolerance policy for employees who are under the influence of illegal drugs or alcohol while at work. Employees who are using marijuana with a valid prescription or authorized by Ohio law are not exempt from this policy in any way. The use of marijuana with or without a valid prescription or as authorized by law will be treated the same as the use of all other illegal drugs or the abuse of legal drugs. Employees using illegal drugs, including marijuana for any purpose including medicinal, are still subject to all provisions of this policy and may be terminated for such use.

Employees are advised of the following:

1. This [County] does not permit or accommodate an employee's use, possession, or distribution of medical marijuana;

2. The [County] may refuse to hire or may discharge, discipline or take other action against an individual because of that person's use, possession, or distribution of medical marijuana;

3. An employee who tests positive for or refuses to submit to a drug test may be disqualified for compensation and benefits under the Ohio Workers' Compensation Act;

4. Because use, possession or distribution of marijuana is a violation of the Drug-Free Workplace Policy, employees who are discharged for those reasons will be considered to have been discharged for just cause for purpose of unemployment compensation or other post-termination pay or benefits.

The Drug-Free Workplace Policy continues to apply regardless of whether the employee's use, possession, or distribution of marijuana was obtained/conducted in Ohio or other states.

ACKNOWLEDGMENT

By signing below, I acknowledge that I have read and understand this Memorandum regarding Medical Marijuana & The Drug-Free Workplace Policy. I also reaffirm my acknowledgement of The Drug-Free Workplace Policy and agree to follow its terms.

_____

Employee Signature Date

Instructions | Start Over | Print

Employment Eligibility Verification

Department of Homeland Security
U.S. Citizenship and Immigration Services

USCIS
Form I-9
OMB No. 1615-0047
Expires 08/31/2019

▶ **START HERE:** **Read instructions carefully before completing this form. The instructions must be available, either in paper or electronically, during completion of this form. Employers are liable for errors in the completion of this form.**

ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers **CANNOT** specify which document(s) an employee may present to establish employment authorization and identity. The refusal to hire or continue to employ an individual because the documentation presented has a future expiration date may also constitute illegal discrimination.

Section 1. Employee Information and Attestation *(Employees must complete and sign Section 1 of Form I-9 no later than the first day of employment, but not before accepting a job offer.)*

Last Name *(Family Name)*	First Name *(Given Name)*	Middle Initial	Other Last Names Used *(if any)*

Address *(Street Number and Name)*	Apt. Number	City or Town	State	ZIP Code

Date of Birth *(mm/dd/yyyy)*	U.S. Social Security Number	Employee's E-mail Address	Employee's Telephone Number

I am aware that federal law provides for imprisonment and/or fines for false statements or use of false documents in connection with the completion of this form.

I attest, under penalty of perjury, that I am (check one of the following boxes):

☐ 1. A citizen of the United States

☐ 2. A noncitizen national of the United States *(See instructions)*

☐ 3. A lawful permanent resident (Alien Registration Number/USCIS Number): _____ _____

☐ 4. An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy): _____
Some aliens may write "N/A" in the expiration date field. *(See instructions)*

Aliens authorized to work must provide only one of the following document numbers to complete Form I-9: An Alien Registration Number/USCIS Number OR Form I-94 Admission Number OR Foreign Passport Number.

1. Alien Registration Number/USCIS Number: _____ _____

OR

2. Form I-94 Admission Number: _____

OR

3. Foreign Passport Number: _____

Country of Issuance: _____

QR Code - Section 1
Do Not Write in This Space

Signature of Employee	Today's Date *(mm/dd/yyyy)*

Preparer and/or Translator Certification (check one):

☐ I did not use a preparer or translator. ☐ A preparer(s) and/or translator(s) assisted the employee in completing Section 1.

(Fields below must be completed and signed when preparers and/or translators assist an employee in completing Section 1.)

I attest, under penalty of perjury, that I have assisted in the completion of Section 1 of this form and that to the best of my knowledge the information is true and correct.

Signature of Preparer or Translator	Today's Date *(mm/dd/yyyy)*

Last Name *(Family Name)*	First Name *(Given Name)*

Address *(Street Number and Name)*	City or Town	State	ZIP Code

Click to Finish

STOP *Employer Completes Next Page* STOP

Instructions | Start Over | Print

Employment Eligibility Verification

Department of Homeland Security
U.S. Citizenship and Immigration Services

USCIS
Form I-9
OMB No. 1615-0047
Expires 08/31/2019

Section 2. Employer or Authorized Representative Review and Verification

(Employers or their authorized representative must complete and sign Section 2 within 3 business days of the employee's first day of employment. You must physically examine one document from List A OR a combination of one document from List B and one document from List C as listed on the "Lists of Acceptable Documents.")

Employee Info from Section 1	Last Name *(Family Name)*	First Name *(Given Name)*	M.I.	Citizenship/Immigration Status

List A Identity and Employment Authorization	OR	List B Identity	AND	List C Employment Authorization
Document Title		Document Title		Document Title
Issuing Authority		Issuing Authority		Issuing Authority
Document Number		Document Number		Document Number
Expiration Date *(if any)(mm/dd/yyyy)*		Expiration Date *(if any)(mm/dd/yyyy)*		Expiration Date *(if any)(mm/dd/yyyy)*
Document Title				
Issuing Authority				
Document Number				
Expiration Date *(if any)(mm/dd/yyyy)*				
Document Title				
Issuing Authority				
Document Number				
Expiration Date *(if any)(mm/dd/yyyy)*				

Additional Information

QR Code - Sections 2 & 3
Do Not Write In This Space

Certification: I attest, under penalty of perjury, that (1) I have examined the document(s) presented by the above-named employee, (2) the above-listed document(s) appear to be genuine and to relate to the employee named, and (3) to the best of my knowledge the employee is authorized to work in the United States.

The employee's first day of employment *(mm/dd/yyyy)*: _____ ***(See instructions for exemptions)***

Signature of Employer or Authorized Representative	Today's Date *(mm/dd/yyyy)*	Title of Employer or Authorized Representative

Last Name of Employer or Authorized Representative	First Name of Employer or Authorized Representative	Employer's Business or Organization Name

Employer's Business or Organization Address (Street Number and Name)	City or Town	State	ZIP Code

Click to Finish

Instructions | Start Over | Print

Employment Eligibility Verification

Department of Homeland Security
U.S. Citizenship and Immigration Services

USCIS
Form I-9
OMB No. 1615-0047
Expires 08/31/2019

Employee Name from Section 1:	Last Name *(Family Name)*	First Name *(Given Name)*	Middle Initial

Section 3. Reverification and Rehires *(To be completed and signed by employer or authorized representative.)*

A. New Name *(if applicable)*			B. Date of Rehire *(if applicable)*
Last Name *(Family Name)*	First Name *(Given Name)*	Middle Initial	Date *(mm/dd/yyyy)*

C. If the employee's previous grant of employment authorization has expired, provide the information for the document or receipt that establishes continuing employment authorization in the space provided below.

Document Title	Document Number	Expiration Date *(if any)* *(mm/dd/yyyy)*

I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented document(s), the document(s) I have examined appear to be genuine and to relate to the individual.

Signature of Employer or Authorized Representative	Today's Date *(mm/dd/yyyy)*	Name of Employer or Authorized Representative

Click to Finish

LISTS OF ACCEPTABLE DOCUMENTS
All documents must be UNEXPIRED

Employees may present one selection from List A
or a combination of one selection from List B and one selection from List C.

LIST A Documents that Establish Both Identity and Employment Authorization	OR	LIST B Documents that Establish Identity	AND	LIST C Documents that Establish Employment Authorization
1. U.S. Passport or U.S. Passport Card		**1.** Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		**1.** A Social Security Account Number card, unless the card includes one of the following restrictions: (1) NOT VALID FOR EMPLOYMENT (2) VALID FOR WORK ONLY WITH INS AUTHORIZATION (3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION
2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)		**2.** ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		**2.** Certification of Birth Abroad issued by the Department of State (Form FS-545)
3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa		**3.** School ID card with a photograph		**3.** Certification of Report of Birth issued by the Department of State (Form DS-1350)
4. Employment Authorization Document that contains a photograph (Form I-766)		**4.** Voter's registration card		**4.** Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal
5. For a nonimmigrant alien authorized to work for a specific employer because of his or her status: **a.** Foreign passport; and **b.** Form I-94 or Form I-94A that has the following: (1) The same name as the passport; and (2) An endorsement of the alien's nonimmigrant status as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form.		**5.** U.S. Military card or draft record		**5.** Native American tribal document
		6. Military dependent's ID card		**6.** U.S. Citizen ID Card (Form I-197)
		7. U.S. Coast Guard Merchant Mariner Card		**7.** Identification Card for Use of Resident Citizen in the United States (Form I-179)
		8. Native American tribal document		**8.** Employment authorization document issued by the Department of Homeland Security
		9. Driver's license issued by a Canadian government authority		
		For persons under age 18 who are unable to present a document listed above:		
		10. School record or report card		
		11. Clinic, doctor, or hospital record		
		12. Day-care or nursery school record		
6. Passport from the Federated States of Micronesia (FSM) or the Republic of the Marshall Islands (RMI) with Form I-94 or Form I-94A indicating nonimmigrant admission under the Compact of Free Association Between the United States and the FSM or RMI				

Examples of many of these documents appear in Part 8 of the Handbook for Employers (M-274).

Refer to the instructions for more information about acceptable receipts.

Addendum

Posters

Ohio Department of Job and Family Services

CIVIL RIGHTS POSTERS FOR EMPLOYERS

JFS 02745 (Rev. 5/2016)

Package contains one copy of the following:

EQUAL EMPLOYMENT OPPORTUNITY IS THE LAW
(English and Spanish)

YOUR RIGHTS UNDER THE FAIR LABOR STANDARDS ACT - FEDERAL MINIMUM WAGE

YOU HAVE THE RIGHT TO A SAFE AND HEALTHFUL WORKPLACE. IT'S THE LAW
(English and Spanish)

NOTICE EMPLOYEE POLYGRAPH PROTECTION ACT
(English and Spanish, two pages)

YOUR RIGHTS UNDER THE FAMILY AND MEDICAL LEAVE ACT OF 1993
(English and Spanish)

YOUR RIGHTS UNDER USERRA

OHIO FAIR EMPLOYMENT PRACTICE LAW

STATE OF OHIO MINIMUM WAGE

STATE OF OHIO MINOR LABOR LAWS

NOTICE TO EMPLOYEES
This employer provides Unemployment Compensation Coverage for Employees JFS 55341 (Rev. 5/2016)
(This poster is not required to be posted)

NO SMOKING

Equal Employment Opportunity is
THE LAW

Private Employers, State and Local Governments, Educational Institutions, Employment Agencies and Labor Organizations

Applicants to and employees of most private employers, state and local governments, educational institutions, employment agencies and labor organizations are protected under Federal law from discrimination on the following bases:

RACE, COLOR, RELIGION, SEX, NATIONAL ORIGIN

Title VII of the Civil Rights Act of 1964, as amended, protects applicants and employees from discrimination in hiring, promotion, discharge, pay, fringe benefits, job training, classification, referral, and other aspects of employment, on the basis of race, color, religion, sex (including pregnancy), or national origin. Religious discrimination includes failing to reasonably accommodate an employee's religious practices where the accommodation does not impose undue hardship.

DISABILITY

Title I and Title V of the Americans with Disabilities Act of 1990, as amended, protect qualified individuals from discrimination on the basis of disability in hiring, promotion, discharge, pay, fringe benefits, job training, classification, referral, and other aspects of employment. Disability discrimination includes not making reasonable accommodation to the known physical or mental limitations of an otherwise qualified individual with a disability who is an applicant or employee, barring undue hardship.

AGE

The Age Discrimination in Employment Act of 1967, as amended, protects applicants and employees 40 years of age or older from discrimination based on age in hiring, promotion, discharge, pay, fringe benefits, job training, classification, referral, and other aspects of employment.

SEX (WAGES)

In addition to sex discrimination prohibited by Title VII of the Civil Rights Act, as amended, the Equal Pay Act of 1963, as amended, prohibits sex discrimination in the payment of wages to women and men performing substantially equal work, in jobs that require equal skill, effort, and responsibility, under similar working conditions, in the same establishment.

GENETICS

Title II of the Genetic Information Nondiscrimination Act of 2008 protects applicants and employees from discrimination based on genetic information in hiring, promotion, discharge, pay, fringe benefits, job training, classification, referral, and other aspects of employment. GINA also restricts employers' acquisition of genetic information and strictly limits disclosure of genetic information. Genetic information includes information about genetic tests of applicants, employees, or their family members; the manifestation of diseases or disorders in family members (family medical history); and requests for or receipt of genetic services by applicants, employees, or their family members.

RETALIATION

All of these Federal laws prohibit covered entities from retaliating against a person who files a charge of discrimination, participates in a discrimination proceeding, or otherwise opposes an unlawful employment practice.

WHAT TO DO IF YOU BELIEVE DISCRIMINATION HAS OCCURRED

There are strict time limits for filing charges of employment discrimination. To preserve the ability of EEOC to act on your behalf and to protect your right to file a private lawsuit, should you ultimately need to, you should contact EEOC promptly when discrimination is suspected:

The U.S. Equal Employment Opportunity Commission (EEOC), 1-800-669-4000 (toll-free) or 1-800-669-6820 (toll-free TTY number for individuals with hearing impairments). EEOC field office information is available at www.eeoc.gov or in most telephone directories in the U.S. Government or Federal Government section. Additional information about EEOC, including information about charge filing, is available at www.eeoc.gov.

Employers Holding Federal Contracts or Subcontracts

Applicants to and employees of companies with a Federal government contract or subcontract are protected under Federal law from discrimination on the following bases:

RACE, COLOR, RELIGION, SEX, NATIONAL ORIGIN

Executive Order 11246, as amended, prohibits job discrimination on the basis of race, color, religion, sex or national origin, and requires affirmative action to ensure equality of opportunity in all aspects of employment.

INDIVIDUALS WITH DISABILITIES

Section 503 of the Rehabilitation Act of 1973, as amended, protects qualified individuals from discrimination on the basis of disability in hiring, promotion, discharge, pay, fringe benefits, job training, classification, referral, and other aspects of employment. Disability discrimination includes not making reasonable accommodation to the known physical or mental limitations of an otherwise qualified individual with a disability who is an applicant or employee, barring undue hardship. Section 503 also requires that Federal contractors take affirmative action to employ and advance in employment qualified individuals with disabilities at all levels of employment, including the executive level.

DISABLED, RECENTLY SEPARATED, OTHER PROTECTED, AND ARMED FORCES SERVICE MEDAL VETERANS

The Vietnam Era Veterans' Readjustment Assistance Act of 1974, as amended, 38 U.S.C. 4212, prohibits job discrimination and requires affirmative action to employ and advance in employment disabled veterans, recently separated veterans (within three years of discharge or release from active duty), other protected veterans (veterans who served during a war or in a campaign or expedition for which a campaign badge has been authorized), and Armed Forces service medal veterans (veterans who, while on active duty, participated in a U.S. military operation for which an Armed Forces service medal was awarded).

RETALIATION

Retaliation is prohibited against a person who files a complaint of discrimination, participates in an OFCCP proceeding, or otherwise opposes discrimination under these Federal laws.

Any person who believes a contractor has violated its nondiscrimination or affirmative action obligations under the authorities above should contact immediately:

The Office of Federal Contract Compliance Programs (OFCCP), U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210, 1-800-397-6251 (toll-free) or (202) 693-1337 (TTY). OFCCP may also be contacted by e-mail at OFCCP-Public@dol.gov, or by calling an OFCCP regional or district office, listed in most telephone directories under U.S. Government, Department of Labor.

Programs or Activities Receiving Federal Financial Assistance

RACE, COLOR, NATIONAL ORIGIN, SEX

In addition to the protections of Title VII of the Civil Rights Act of 1964, as amended, Title VI of the Civil Rights Act of 1964, as amended, prohibits discrimination on the basis of race, color or national origin in programs or activities receiving Federal financial assistance. Employment discrimination is covered by Title VI if the primary objective of the financial assistance is provision of employment, or where employment discrimination causes or may cause discrimination in providing services under such programs. Title IX of the Education Amendments of 1972 prohibits employment discrimination on the basis of sex in educational programs or activities which receive Federal financial assistance.

INDIVIDUALS WITH DISABILITIES

Section 504 of the Rehabilitation Act of 1973, as amended, prohibits employment discrimination on the basis of disability in any program or activity which receives Federal financial assistance. Discrimination is prohibited in all aspects of employment against persons with disabilities who, with or without reasonable accommodation, can perform the essential functions of the job.

If you believe you have been discriminated against in a program of any institution which receives Federal financial assistance, you should immediately contact the Federal agency providing such assistance.

La Igualdad de Oportunidades en el Empleo es

LA LEY

Empleadores privados, autoridades locales y estatales, instituciones educativas, agencias de empleo y organizaciones laborales

Los solicitantes de empleo y los empleados de la mayoría de los empleadores privados, autoridades locales y estatales, instituciones educativas, agencias de empleo y organizaciones laborales están protegidos conforme a la ley federal contra la discriminación por cualquiera de los siguientes motivos:

RAZA, COLOR, RELIGIÓN, SEXO, ORIGEN NACIONAL
El Título VII de la Ley de Derechos Civiles de 1964, y sus enmiendas, protege a los solicitantes de empleo y a los empleados contra la discriminación en la contratación, ascenso, despido, sueldo, beneficios adicionales, capacitación laboral, clasificación, referencia, y otros aspectos del empleo, debido a la raza, color, religión, sexo (incluido el embarazo) u origen nacional. La discriminación religiosa incluye el no realizar los arreglos razonables para las prácticas religiosas de un empleado, cuando tales arreglos no impongan una dificultad indebida.

DISCAPACIDAD
El Título I y el Título V de la Ley de Estadounidenses con Discapacidades de 1990, y sus enmiendas, protegen a los individuos que califiquen contra la discriminación por una discapacidad en la contratación, ascenso, despido, sueldo, beneficios adicionales, capacitación laboral, clasificación, referencia, y otros aspectos del empleo. La discriminación por discapacidad incluye el no realizar los arreglos razonables para las limitaciones mentales o físicas conocidas de un individuo con una discapacidad quien solicite empleo o sea empleado, salvo que implique una dificultad indebida.

EDAD
La Ley Contra la Discriminación por Edad en el Empleo de 1967, y sus enmiendas, protége a los solicitantes de empleo y a los empleados que tengan 40 años de edad o más contra la discriminación por la edad en la contratación, ascenso, despido, sueldo, beneficios adicionales, capacitación laboral, clasificación, referencia, y otros aspectos del empleo.

SEXO (SALARIOS)
Adicionalmente a la prohibición de la discriminación por sexo estipulada en el Título VII de la Ley de Derechos Civiles, y sus enmiendas, la Ley de Igualdad Salarial de 1963, y sus enmiendas, prohíbe la discriminación por sexo en el pago de salarios a los hombres y mujeres que realicen un trabajo sustancialmente similar, en empleos que requieran iguales destrezas, esfuerzos y responsabilidades, bajo condiciones laborales similares, en el mismo establecimiento.

GENÉTICA
El Título II de la Ley contra la Discriminación por Información Genética de 2008 (GINA) protege a los solicitantes de empleo y a los empleados contra la discriminación con basada en información genética, en la contratación, ascenso, despido, sueldo, beneficios adicionales, capacitación laboral, clasificación, referencia, y otros aspectos del empleo. GINA también restringe la adquisición de la información genética por parte de los empleadores y limita estrictamente la divulgación de la información genética. La información genética incluye la información sobre las pruebas genéticas de los solicitantes de empleo, los empleados o sus familiares; la manifestación de enfermedades o desordenes en los familiares (historial médico familiar); y las solicitudes o recibo de servicios genéticos por los solicitantes de empleo, los empleados o sus familiares.

REPRESALIA
Todas estas leyes federales prohíben a las entidades cubiertas tomar represalias contra una persona que presente un cargo de discriminación, participe en un procedimiento de discriminación o se oponga a una práctica laboral ilegal.

QUÉ DEBE HACER SI CONSIDERA QUE HA OCURRIDO UNA DISCRIMINACIÓN
Hay límites estrictos de tiempo para presentar cargos de discriminación en el empleo. Para conservar la capacidad del EEOC de actuar en su nombre y para proteger su derecho de presentar una demanda privada, en caso de que en última instancia lo necesite, usted debe comunicarse con el EEOC de manera oportuna cuando sospeche de la discriminación:
La Comisión para la Igualdad de Oportunidades en el Empleo de los EE.UU. (EEOC), 1-800-669-4000 (número gratuito) o 1-800-669-6820 (número TTY gratuito para las personas con dificultades auditivas). La información de las oficinas de campo del EEOC está disponible en www.eeoc.gov o en la mayoría de los directorios telefónicos en la sección de Gobierno de los EE.UU. o Gobierno Federal. Puede encontrar información adicional sobre el EEOC, incluida la información sobre la presentación de cargos, en www.eeoc.gov.

Empleadores que tengan contratos o subcontratos federales

Los solicitantes de empleo y los empleados de compañías con un contrato o subcontrato gubernamental federal están protegidos conforme a las leyes federales contra la discriminación por los siguientes motivos:

RAZA, COLOR, RELIGIÓN, SEXO, ORIGEN NACIONAL
La Orden Ejecutiva 11246, y sus enmiendas, prohíbe la discriminación en el trabajo por motivo de raza, color, religión, sexo u origen nacional, y exige la aplicación de acción afirmativa para garantizar la igualdad en las oportunidades en todos los aspectos del empleo.

INDIVIDUOS CON DISCAPACIDADES
La Sección 503 de la Ley de Rehabilitación de 1973, y sus enmiendas, protege a los individuos que califiquen contra la discriminación por una discapacidad en la contratación, ascenso, despido, sueldo, beneficios adicionales, capacitación laboral, clasificación, referencia, y otros aspectos del empleo. La discriminación por discapacidad incluye el no realizar los arreglos razonables para las limitaciones mentales o físicas conocidas de un individuo con una discapacidad quien solicite empleo o sea empleado, salvo que implique una dificultad indebida. La Sección 503 también exige que los contratistas federales tomen las acciones afirmativas para emplear y ascender en el empleo a individuos calificados con discapacidades en todos los niveles laborales, incluido el nivel ejecutivo.

VETERANOS CON MEDALLAS DEL SERVICIO DE LAS FUERZAS ARMADAS Y VETERANOS DISCAPACITADOS, SEPARADOS RECIENTEMENTE Y DE OTRO ESTATUS PROTEGIDO
La Ley de Asistencia a la Readaptación de los Veteranos de Vietnam de 1974, y sus enmiendas, 38 U.S.C. 4212, prohíbe la discriminación laboral y exige la acción afirmativa para emplear y ascender en el empleo a veteranos discapacitados, veteranos separados del servicio recientemente (dentro de los tres años dados de baja del servicio activo), otros veteranos protegidos (quienes hayan prestado el servicio militar en una guerra o en una campaña o expedición para la cual se haya autorizado una insignia de campaña), y los veteranos con medallas del Servicio de las Fuerzas Armadas (veteranos quienes, mientras se encontraban en el servicio activo, participaron en una operación militar de EE.UU. para la cual se les otorgó una medalla del Servicio de las Fuerzas Armadas).

REPRESALIA
Se prohíben las represalias contra una persona que presente un cargo de discriminación, participe en un procedimiento de la Oficina de Programas de Cumplimiento de Contratos Federales (OFCCP), o quien se oponga a la discriminación de conformidad con estas leyes federales.

Toda persona quien considere que un contratista ha incumplido sus obligaciones antidiscriminatorias o de acción afirmativa conforme a las autoridades antes indicadas, debe contactar de inmediato a:

The Office of Federal Contract Compliance Programs (OFCCP), U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210, 1-800-397-6251 (número gratuito) o (202) 693-1337 (número TTY). También puede contactar a la OFCCP por el correo electrónico OFCCP-Public@dol.gov, o llamando a una oficina distrital o regional de la OFCCP, la cual puede encontrar en la mayoría de los directorios telefónicos en la sección U.S. Government (Gobierno de los EE.UU.), Department of Labor (Departamento del Trabajo).

Programas o actividades que reciban asistencia financiera federal

RAZA, COLOR, ORIGEN NACIONAL, SEXO
Adicionalmente a las protecciones del Título VII de la Ley de Derechos Civiles de 1964, y sus enmiendas, el Título VI de la Ley de Derechos Civiles de 1964, y sus enmiendas, prohíbe la discriminación por raza, color u origen nacional en los programas o actividades que reciban asistencia financiera federal. La discriminación en el empleo está cubierta por el Título VI si el objetivo principal de la asistencia financiera es la provisión del empleo, o donde la discriminación laboral cause o pueda causar una discriminación en la provisión de los servicios conforme a tales programas. El Título IX de las Enmiendas en la Educación de 1972 prohíbe la discriminación en el empleo por motivo del sexo en las actividades o programas educativos que reciban asistencia financiera federal.

INDIVIDUOS CON DISCAPACIDADES
La Sección 504 de la Ley de Rehabilitación de 1973, y sus enmiendas, prohíbe la discriminación en el empleo por una discapacidad, en cualquier programa o actividad que reciba asistencia financiera federal. Se prohíbe la discriminación en todos los aspectos del empleo contra las personas con discapacidades quienes, con o sin arreglos razonables, puedan realizar las funciones esenciales del trabajo.

Si usted considera que ha sido discriminado en un programa de alguna institución que reciba asistencia financiera federal, debe contactar inmediatamente a la agencia federal que proporciona dicha asistencia.

EMPLOYEE RIGHTS

UNDER THE FAIR LABOR STANDARDS ACT

FEDERAL MINIMUM WAGE

$7.25 PER HOUR

BEGINNING JULY 24, 2009

The law requires employers to display this poster where employees can readily see it.

OVERTIME PAY At least 1½ times the regular rate of pay for all hours worked over 40 in a workweek.

CHILD LABOR An employee must be at least 16 years old to work in most non-farm jobs and at least 18 to work in non-farm jobs declared hazardous by the Secretary of Labor. Youths 14 and 15 years old may work outside school hours in various non-manufacturing, non-mining, non-hazardous jobs with certain work hours restrictions. Different rules apply in agricultural employment.

TIP CREDIT Employers of "tipped employees" who meet certain conditions may claim a partial wage credit based on tips received by their employees. Employers must pay tipped employees a cash wage of at least $2.13 per hour if they claim a tip credit against their minimum wage obligation. If an employee's tips combined with the employer's cash wage of at least $2.13 per hour do not equal the minimum hourly wage, the employer must make up the difference.

NURSING MOTHERS The FLSA requires employers to provide reasonable break time for a nursing mother employee who is subject to the FLSA's overtime requirements in order for the employee to express breast milk for her nursing child for one year after the child's birth each time such employee has a need to express breast milk. Employers are also required to provide a place, other than a bathroom, that is shielded from view and free from intrusion from coworkers and the public, which may be used by the employee to express breast milk.

ENFORCEMENT The Department has authority to recover back wages and an equal amount in liquidated damages in instances of minimum wage, overtime, and other violations. The Department may litigate and/or recommend criminal prosecution. Employers may be assessed civil money penalties for each willful or repeated violation of the minimum wage or overtime pay provisions of the law. Civil money penalties may also be assessed for violations of the FLSA's child labor provisions. Heightened civil money penalties may be assessed for each child labor violation that results in the death or serious injury of any minor employee, and such assessments may be doubled when the violations are determined to be willful or repeated. The law also prohibits retaliating against or discharging workers who file a complaint or participate in any proceeding under the FLSA.

ADDITIONAL INFORMATION

- Certain occupations and establishments are exempt from the minimum wage, and/or overtime pay provisions.
- Special provisions apply to workers in American Samoa, the Commonwealth of the Northern Mariana Islands, and the Commonwealth of Puerto Rico.
- Some state laws provide greater employee protections; employers must comply with both.
- Some employers incorrectly classify workers as "independent contractors" when they are actually employees under the FLSA. It is important to know the difference between the two because employees (unless exempt) are entitled to the FLSA's minimum wage and overtime pay protections and correctly classified independent contractors are not.
- Certain full-time students, student learners, apprentices, and workers with disabilities may be paid less than the minimum wage under special certificates issued by the Department of Labor.

WAGE AND HOUR DIVISION
UNITED STATES DEPARTMENT OF LABOR

1-866-487-9243
TTY: 1-877-889-5627
www.dol.gov/whd

U.S. Department of Labor

OSHA® Occupational Safety and Health Administration

Job Safety and Health
IT'S THE LAW!

All workers have the right to:

- A safe workplace.
- Raise a safety or health concern with your employer or OSHA, or report a work-related injury or illness, without being retaliated against.
- Receive information and training on job hazards, including all hazardous substances in your workplace.
- Request an OSHA inspection of your workplace if you believe there are unsafe or unhealthy conditions. OSHA will keep your name confidential. You have the right to have a representative contact OSHA on your behalf.
- Participate (or have your representative participate) in an OSHA inspection and speak in private to the inspector.
- File a complaint with OSHA within 30 days (by phone, online or by mail) if you have been retaliated against for using your rights.
- See any OSHA citations issued to your employer.
- Request copies of your medical records, tests that measure hazards in the workplace, and the workplace injury and illness log.

This poster is available free from OSHA.

Employers must:

- Provide employees a workplace free from recognized hazards. It is illegal to retaliate against an employee for using any of their rights under the law, including raising a health and safety concern with you or with OSHA, or reporting a work-related injury or illness.
- Comply with all applicable OSHA standards.
- Report to OSHA all work-related fatalities within 8 hours, and all inpatient hospitalizations, amputations and losses of an eye within 24 hours.
- Provide required training to all workers in a language and vocabulary they can understand.
- Prominently display this poster in the workplace.
- Post OSHA citations at or near the place of the alleged violations.

FREE ASSISTANCE to identify and correct hazards is available to small and medium-sized employers, without citation or penalty, through OSHA-supported consultation programs in every state.

Contact OSHA. We can help.

1-800-321-OSHA (6742) • TTY 1-877-889-5627 • www.osha.gov

OSHA 3165-04R 2015

Departamento de Trabajo de los EE. UU.

OSHA®
Administración de Seguridad y Salud Ocupacional

Seguridad y Salud en el Trabajo
¡ES LA LEY!

Todos los trabajadores tienen el derecho a:

- Un lugar de trabajo seguro.
- Decir algo a su empleador o la OSHA sobre preocupaciones de seguridad o salud, o reportar una lesión o enfermedad en el trabajo, sin sufrir represalias.
- Recibir información y entrenamiento sobre los peligros del trabajo, incluyendo sustancias toxicas en su sitio de trabajo.
- Pedirle a la OSHA inspeccionar su lugar de trabajo si usted cree que hay condiciones peligrosas o insalubres. Su información es confidencial. Algún representante suyo puede comunicarse con OSHA a su nombre.
- Participar (o su representante puede participar) en la inspección de OSHA y hablar en privado con el inspector.
- Presentar una queja con la OSHA dentro de 30 días (por teléfono, por internet, o por correo) si usted ha sufrido represalias por ejercer sus derechos.
- Ver cualquieras citaciones de la OSHA emitidas a su empleador.
- Pedir copias de sus registros médicos, pruebas que miden los peligros en el trabajo, y registros de lesiones y enfermedades relacionadas con el trabajo.

Este cartel está disponible de la OSHA para gratis.

Los empleadores deben:

- Proveer a los trabajadores un lugar de trabajo libre de peligros reconocidos. Es ilegal discriminar contra un empleado quien ha ejercido sus derechos bajo la ley, incluyendo hablando sobre preocupaciones de seguridad o salud a usted o con la OSHA, o por reportar una lesión o enfermedad relacionada con el trabajo.
- Cumplir con todas las normas aplicables de la OSHA.
- Reportar a la OSHA todas las fatalidades relacionadas con el trabajo dentro de 8 horas, y todas hospitalizaciones, amputaciones y la perdida de un ojo dentro de 24 horas.
- Proporcionar el entrenamiento requerido a todos los trabajadores en un idioma y vocabulario que pueden entender.
- Mostrar claramente este cartel en el lugar de trabajo.
- Mostrar las citaciones de la OSHA acerca del lugar de la violación alegada.

Los empleadores de tamaño pequeño y mediano pueden recibir ASISTENCIA GRATIS para identificar y corregir los peligros sin citación o multa, a través de los programas de consultación apoyados por la OSHA en cada estado.

Llame OSHA. Podemos ayudar.

1-800-321-OSHA (6742) • TTY 1-877-889-5627 • www.osha.gov/spanish

OSHA 3167-04R 2015
It's the Law – Spanish

EMPLOYEE RIGHTS

EMPLOYEE POLYGRAPH PROTECTION ACT

The Employee Polygraph Protection Act prohibits most private employers from using lie detector tests either for pre-employment screening or during the course of employment.

PROHIBITIONS

Employers are generally prohibited from requiring or requesting any employee or job applicant to take a lie detector test, and from discharging, disciplining, or discriminating against an employee or prospective employee for refusing to take a test or for exercising other rights under the Act.

EXEMPTIONS

Federal, State and local governments are not affected by the law. Also, the law does not apply to tests given by the Federal Government to certain private individuals engaged in national security-related activities.

The Act permits polygraph (a kind of lie detector) tests to be administered in the private sector, subject to restrictions, to certain prospective employees of security service firms (armored car, alarm, and guard), and of pharmaceutical manufacturers, distributors and dispensers.

The Act also permits polygraph testing, subject to restrictions, of certain employees of private firms who are reasonably suspected of involvement in a workplace incident (theft, embezzlement, etc.) that resulted in economic loss to the employer.

The law does not preempt any provision of any State or local law or any collective bargaining agreement which is more restrictive with respect to lie detector tests.

EXAMINEE RIGHTS

Where polygraph tests are permitted, they are subject to numerous strict standards concerning the conduct and length of the test. Examinees have a number of specific rights, including the right to a written notice before testing, the right to refuse or discontinue a test, and the right not to have test results disclosed to unauthorized persons.

ENFORCEMENT

The Secretary of Labor may bring court actions to restrain violations and assess civil penalties against violators. Employees or job applicants may also bring their own court actions.

THE LAW REQUIRES EMPLOYERS TO DISPLAY THIS POSTER WHERE EMPLOYEES AND JOB APPLICANTS CAN READILY SEE IT.

WHD
WAGE AND HOUR DIVISION
UNITED STATES DEPARTMENT OF LABOR

1-866-487-9243
TTY: 1-877-889-5627
www.dol.gov/whd

DERECHOS DEL EMPLEADO

LEY PARA LA PROTECCIÓN DEL EMPLEADO CONTRA LA PRUEBA DEL POLÍGRAFO

La Ley Para La Protección del Empleado contra la Prueba de Polígrafo le prohíbe a la mayoría de los empleadores del sector privado que utilice pruebas con detectores de mentiras durante el período de pre-empleo o durante el servicio de empleo.

PROHIBICIONES Generalmente se le prohíbe al empleador que le exija o requiera a un empleado o a un solicitante a un trabajo que se someta a una prueba con detector de mentiras, y que despida, discipline, o discrimine de ninguna forma contra un empleado o contra un aspirante a un trabajo por haberse negado a someterse a la prueba o por haberse acogido a otros derechos establecidos por la Ley.

EXENCIONES Esta Ley no afecta a los empleados de los gobiernos federal, estatales y locales. Tampoco se aplica a las pruebas que el Gobierno Federal les administra a ciertos individuos del sector privado que trabajan en actividades relacionadas con la seguridad nacional.

La Ley permite la administración de pruebas de polígrafo (un tipo de detector de mentiras) en el sector privado, sujeta a ciertas restricciones, a ciertos aspirantes para empleos en compañías de seguridad (vehículos blindados, sistemas de alarma y guardias). También se les permite el uso de éstas a compañías que fabrican, distribuyen y dispensan productos farmacéuticos.

La Ley también permite la administración de estas pruebas de polígrafo, sujeta a ciertas restricciones, a empleados de empresas privadas que estén bajo sospecha razonable de estar involucrados en un incidente en el sitio de empleo (tal como un robo, desfalco, etc.) que le haya ocasionado daños económicos al empleador.

La Ley no substituye ninguna provisión de cualquier otra ley estatal o local ni tampoco a tratos colectivos que sean más rigurosos con respecto a las pruebas de polígrafo.

DERECHOS DE LOS EXAMINADOS En casos en que se permitan las pruebas de polígrafo, éstas deben ser administradas bajo una cantidad de normas estrictas en cuanto a su administración y duración. Los examinados tienen un número de derechos específicos, incluyendo el derecho de advertencia por escrito antes de someterse a la prueba, el derecho a negarse a someterse a la prueba o a descontinuarla, al igual que el derecho a negarse a que los resultados de la prueba estén al alcance de personas no autorizadas.

CUMPLIMIENTO El/La Secretario(a) de Trabajo puede entablar pleitos para impedir violaciones y puede imponer penas pecuniarias civiles contra los violadores. Los empleados o solicitantes a empleo también tienen derecho a entablar sus propios pleitos en los tribunales.

LA LEY EXIGE QUE LOS EMPLEADORES EXHIBAN ESTE AVISO DONDE LOS EMPLEADOS Y LOS SOLICITANTES DE EMPLEO LO PUEDAN VER FÁCILMENTE.

WHD
DIVISIÓN DE HORAS Y SALARIOS
DEPARTAMENTO DE TRABAJO DE LOS EE.UU.

1-866-487-9243
TTY: 1-877-889-5627
www.dol.gov/whd

WH1462 SPA REV 07/16

EMPLOYEE RIGHTS
UNDER THE FAMILY AND MEDICAL LEAVE ACT

THE UNITED STATES DEPARTMENT OF LABOR WAGE AND HOUR DIVISION

LEAVE ENTITLEMENTS

Eligible employees who work for a covered employer can take up to 12 weeks of unpaid, job-protected leave in a 12-month period for the following reasons:

- The birth of a child or placement of a child for adoption or foster care;
- To bond with a child (leave must be taken within 1 year of the child's birth or placement);
- To care for the employee's spouse, child, or parent who has a qualifying serious health condition;
- For the employee's own qualifying serious health condition that makes the employee unable to perform the employee's job;
- For qualifying exigencies related to the foreign deployment of a military member who is the employee's spouse, child, or parent.

An eligible employee who is a covered servicemember's spouse, child, parent, or next of kin may also take up to 26 weeks of FMLA leave in a single 12-month period to care for the servicemember with a serious injury or illness.

An employee does not need to use leave in one block. When it is medically necessary or otherwise permitted, employees may take leave intermittently or on a reduced schedule.

Employees may choose, or an employer may require, use of accrued paid leave while taking FMLA leave. If an employee substitutes accrued paid leave for FMLA leave, the employee must comply with the employer's normal paid leave policies.

BENEFITS & PROTECTIONS

While employees are on FMLA leave, employers must continue health insurance coverage as if the employees were not on leave.

Upon return from FMLA leave, most employees must be restored to the same job or one nearly identical to it with equivalent pay, benefits, and other employment terms and conditions.

An employer may not interfere with an individual's FMLA rights or retaliate against someone for using or trying to use FMLA leave, opposing any practice made unlawful by the FMLA, or being involved in any proceeding under or related to the FMLA.

ELIGIBILITY REQUIREMENTS

An employee who works for a covered employer must meet three criteria in order to be eligible for FMLA leave. The employee must:

- Have worked for the employer for at least 12 months;
- Have at least 1,250 hours of service in the 12 months before taking leave;* and
- Work at a location where the employer has at least 50 employees within 75 miles of the employee's worksite.

*Special "hours of service" requirements apply to airline flight crew employees.

REQUESTING LEAVE

Generally, employees must give 30-days' advance notice of the need for FMLA leave. If it is not possible to give 30-days' notice, an employee must notify the employer as soon as possible and, generally, follow the employer's usual procedures.

Employees do not have to share a medical diagnosis, but must provide enough information to the employer so it can determine if the leave qualifies for FMLA protection. Sufficient information could include informing an employer that the employee is or will be unable to perform his or her job functions, that a family member cannot perform daily activities, or that hospitalization or continuing medical treatment is necessary. Employees must inform the employer if the need for leave is for a reason for which FMLA leave was previously taken or certified.

Employers can require a certification or periodic recertification supporting the need for leave. If the employer determines that the certification is incomplete, it must provide a written notice indicating what additional information is required.

EMPLOYER RESPONSIBILITIES

Once an employer becomes aware that an employee's need for leave is for a reason that may qualify under the FMLA, the employer must notify the employee if he or she is eligible for FMLA leave and, if eligible, must also provide a notice of rights and responsibilities under the FMLA. If the employee is not eligible, the employer must provide a reason for ineligibility.

Employers must notify its employees if leave will be designated as FMLA leave, and if so, how much leave will be designated as FMLA leave.

ENFORCEMENT

Employees may file a complaint with the U.S. Department of Labor, Wage and Hour Division, or may bring a private lawsuit against an employer.

The FMLA does not affect any federal or state law prohibiting discrimination or supersede any state or local law or collective bargaining agreement that provides greater family or medical leave rights.

For additional information or to file a complaint:

1-866-4-USWAGE

(1-866-487-9243) TTY: 1-877-889-5627

www.dol.gov/whd

U.S. Department of Labor | Wage and Hour Division

WH1420 REV 04/16

YOUR RIGHTS UNDER USERRA

THE UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT

USERRA protects the job rights of individuals who voluntarily or involuntarily leave employment positions to undertake military service or certain types of service in the National Disaster Medical System. USERRA also prohibits employers from discriminating against past and present members of the uniformed services, and applicants to the uniformed services.

REEMPLOYMENT RIGHTS

You have the right to be reemployed in your civilian job if you leave that job to perform service in the uniformed service and:

- ☆ you ensure that your employer receives advance written or verbal notice of your service;
- ☆ you have five years or less of cumulative service in the uniformed services while with that particular employer;
- ☆ you return to work or apply for reemployment in a timely manner after conclusion of service; and
- ☆ you have not been separated from service with a disqualifying discharge or under other than honorable conditions.

If you are eligible to be reemployed, you must be restored to the job and benefits you would have attained if you had not been absent due to military service or, in some cases, a comparable job.

RIGHT TO BE FREE FROM DISCRIMINATION AND RETALIATION

If you:

- ☆ are a past or present member of the uniformed service;
- ☆ have applied for membership in the uniformed service; or
- ☆ are obligated to serve in the uniformed service;

then an employer may not deny you:

- ☆ initial employment;
- ☆ reemployment;
- ☆ retention in employment;
- ☆ promotion; or
- ☆ any benefit of employment

because of this status.

In addition, an employer may not retaliate against anyone assisting in the enforcement of USERRA rights, including testifying or making a statement in connection with a proceeding under USERRA, even if that person has no service connection.

HEALTH INSURANCE PROTECTION

- ☆ If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your dependents for up to 24 months while in the military.
- ☆ Even if you don't elect to continue coverage during your military service, you have the right to be reinstated in your employer's health plan when you are reemployed, generally without any waiting periods or exclusions (e.g., pre-existing condition exclusions) except for service-connected illnesses or injuries.

ENFORCEMENT

- ☆ The U.S. Department of Labor, Veterans Employment and Training Service (VETS) is authorized to investigate and resolve complaints of USERRA violations.
- ☆ For assistance in filing a complaint, or for any other information on USERRA, contact VETS at **1-866-4-USA-DOL** or visit its **website at http://www.dol.gov/vets**. An interactive online USERRA Advisor can be viewed at **http://www.dol.gov/elaws/userra.htm**.
- ☆ If you file a complaint with VETS and VETS is unable to resolve it, you may request that your case be referred to the Department of Justice or the Office of Special Counsel, as applicable, for representation.
- ☆ You may also bypass the VETS process and bring a civil action against an employer for violations of USERRA.

The rights listed here may vary depending on the circumstances. The text of this notice was prepared by VETS, and may be viewed on the internet at this address: http://www.dol.gov/vets/programs/userra/poster.htm. Federal law requires employers to notify employees of their rights under USERRA, and employers may meet this requirement by displaying the text of this notice where they customarily place notices for employees.

U.S. Department of Labor | U.S. Department of Justice | Office of Special Counsel | 1-800-336-4590

STATE OF OHIO

2017 MINIMUM WAGE

OHIO DEPARTMENT OF COMMERCE
DIVISION OF INDUSTRIAL COMPLIANCE

www.com.ohio.gov

John R. Kasich
Governor

Jacqueline T. Williams
Director

NON-TIPPED EMPLOYEES

A Minimum Wage of
$8.15 per hour

"Non-Tipped Employees" includes any employee who does not engage in an occupation in which he/she customarily and regularly receives more than thirty dollars ($30.00) per month in tips.

"Employers" who gross less than $299,000 shall pay their employees no less than the current federal minimum wage rate.

"Employees" under the age of 16 shall be paid no less then the current federal minimum wage rate.

"Current Federal Minimum Wage" is $7.25 per hour.

TIPPED EMPLOYEES

A Minimum Wage of
$4.08 per hour **PLUS TIPS**

"Tipped Employees" includes any employee who engages in an occupation in which he/she customarily and regularly receives more than thirty dollars ($30.00) per month in tips. Employers electing to use the tip credit provision must be able to show that tipped employees receive at least the minimum wage when direct or cash wages and the tip credit amount are combined.

OVERTIME

1. An employer shall pay an employee for overtime at a wage rate of one and one-half times the employee's wage rate for hours in excess of forty hours in one work week, except for employers grossing less than $150,000 per year.

RECORDS TO BE KEPT BY THE EMPLOYER

1. Each employer shall keep records for at least three years, available for copying and inspection by the Director of the Ohio Department of Commerce, showing the following information concerning each employee:

   A. Name
   B. Address
   C. Occupation
   D. Rate of Pay
   E. Amount paid each pay period
   F. Hours worked each day and each work week

2. The records may be opened for inspection or copying at any reasonable time and no employer shall hinder or delay the Director of the Ohio Department of Commerce in the performance of these duties.

SUB-MINIMUM WAGE RATE

To prevent the curtailment of opportunities for employment and avoid undue hardship to individuals whose earning capacity is affected or impaired by physical or mental deficiencies or injuries, a sub-minimum wage may be paid, as provided in the rules and regulations set forth by the Director of the Ohio Department of Commerce.

INDIVIDUALS EXEMPT FROM MINIMUM WAGE

1. Any individual employed by the United States;

2. Any individual employed as a baby-sitter in the employer's home, or a live-in companion to a sick, convalescing, or elderly person whose principal duties do not include housekeeping;

3. Any individual employed as an outside salesman compensated by commissions or in a bona fide executive, administrative, or professional capacity, or computer professionals;

4. Any individual who volunteers to perform services for a public agency which is a State, a political subdivision of a State, or an interstate government agency, if
   (i) the individual receives no compensation or is paid expenses, reasonable benefits, or a nominal fee to perform the services for which the individual volunteered; and
   (ii) such services are not the same type of services which the individual is employed to perform for such public agency;

5. Any individual who works or provides personal services of a charitable nature in a hospital or health institution for which compensation is not sought or contemplated;

6. Any individual in the employ of a camp or recreational area for children under eighteen years of age and owned and operated by a non-profit organization or group of organizations.

7. Employees of a solely family owned and operated business who are family members of an owner.

For further information about minimum wage issues, please contact: The Ohio Department of Commerce, Division of Industrial Compliance, 6606 Tussing Road, Reynoldsburg, Ohio 43068. Phone: (614) 644-2239. TTY/TDD: 1-800-750-0750. An Equal Opportunity Employer and Service Provider. (REV. 9/30/16)

POST IN A CONSPICUOUS PLACE

Know Your Rights

Governor John Kasich

G. Michael Payton
Executive Director

EQUAL EMPLOYMENT OPPORTUNITY IS THE LAW

The Ohio Civil Rights Act *protects applicants and employees of private employers, state, county and local governments, educational institutions, labor organizations, employment agencies and personnel placement services from unlawful discriminatory employment practices.*

Race and Color

Ohio law prohibits discrimination on the basis of ***race or color*** in hiring, promotion, tenure, discharge, pay, fringe benefits, job training, classification, referral, terms, conditions and privileges of employment, or any other matter directly or indirectly related to employment.

In addition, any facially neutral employment policy or practice that results in a discriminatory impact on the basis of race or color is a prohibited form of discrimination unless such policy or practice is job-related and based upon business necessity.

National Origin and Ancestry

Ohio law prohibits discrimination on the basis of ***national origin or ancestry*** in hiring, promotion, tenure, discharge, pay, fringe benefits, job training, classification, referral, terms, conditions and privileges of employment, or any other matter directly or indirectly related to employment.

In addition, any policy or practice limiting or prohibiting the use of any language in the workplace is a prohibited form of discrimination unless such limitation or prohibition is job -related and based upon business necessity.

Military Status

Ohio law prohibits discrimination on the basis of ***military status*** in hiring, promotion, tenure, discharge, pay, fringe benefits, job training, classification, referral, terms, conditions and privileges of employment, or any other matter directly or indirectly related to employment.

In addition, employees who leave employment to perform military service, which includes the performance of duty, on a voluntary or involuntary basis, in a uniformed service, under competent authority, must be reemployed upon conclusion of such service.

Harassment

Ohio law prohibits harassment in the workplace on any basis set forth herein, which includes the creation of a racially or sexually hostile work environment, verbally or physically abusive treatment, and requiring submission to sexual advances as a condition of employment, continued employment or promotion.

In addition, all reasonable steps should be taken to prevent and promptly correct harassment in the workplace, which includes the establishment of a policy against harassment and a procedure for receiving, investigating and remedying complaints of workplace harassment.

Sex and Pregnancy

Ohio law prohibits discrimination on the basis of ***sex or pregnancy*** in hiring, promotion, tenure, discharge, pay, fringe benefits, job training, classification, referral, terms, conditions and privileges of employment, or any other matter directly or indirectly related to employment.

In addition, women affected by pregnancy, childbirth or related medical condition must be afforded leave for a reasonable period of time and may not be discharged under a policy providing insufficient or no leave.

Disability

Ohio law prohibits discrimination on the basis of ***disability*** in hiring, promotion, tenure, discharge, pay, fringe benefits, job training, classification, referral, terms, conditions and privileges of employment, or any other matter directly or indirectly related to employment.

In addition, applicants and employees must be provided with a reasonable accommodation for their disabilities, except when the accommodation imposes an undue hardship.

Age

Ohio law prohibits discrimination against persons ***40 years of age or older*** on the basis of ***age*** in hiring, promotion, tenure, discharge, pay, fringe benefits, job training, classification, referral, terms, conditions and privileges of employment, or any other matter directly or indirectly related to employment.

Religion

Ohio law prohibits discrimination on the basis of ***religion*** in hiring, promotion, tenure, discharge, pay, fringe benefits, job training, classification, referral, terms, conditions and privileges of employment, or any other matter directly or indirectly related to employment.

In addition, applicants and employees must be provided with a reasonable accommodation for religious beliefs and practices, except when the accommodation imposes an undue hardship.

Retaliation

Ohio law prohibits retaliation against any person because that person has opposed any unlawful discriminatory practice, or because that person has made a charge, testified, assisted or participated in any manner in any investigation, proceeding or hearing.

ENFORCEMENT

The Ohio Civil Rights Commission (OCRC) investigates complaints of discrimination and harassment in employment.

Complaints must be filed with the OCRC within six months of the last act of discrimination or harassment.

For assistance in filing a complaint, or for any other information on the Civil Rights Act, please call **1-888-278-7101** or **(614) 752-2391 (TTY)**, or visit our website at:

crc.ohio.gov

Publication Date 01-2011 Cost: $0.1942

STATE OF OHIO

MINOR LABOR LAWS

OHIO DEPARTMENT OF COMMERCE
DIVISION OF INDUSTRIAL COMPLIANCE & LABOR
www.com.ohio.gov/

JOHN KASICH
Governor

DAVID GOODMAN
Director

*OHIO REVISED CODE CHAPTER 4109**
"MINOR" MEANS ANY PERSON LESS THAN 18 YEARS OF AGE

WORKING PERMITS: Every minor 14 through 17 years of age must have a working permit unless otherwise stated in Chapter 4109.
WAGE AGREEMENT: No employer shall give employment to a minor without agreeing with him/her as to the wages or compensation he/she shall receive for each day, week, month, year or per piece for work performed.
REST PERIOD: No employer shall employ a minor more than 5 consecutive hours without a rest period of at least 30 minutes.
LIST OF MINORS EMPLOYED: Employer shall keep a list of minors employed at each establishment and a list must be posted in a conspicuous place to which all minor employees have access.
TIME RECORDS: Every employer shall keep a time book or other written record showing actual starting and stopping time of each work and rest period. These records must be kept for two (2) years.

RESTRICTIONS ON WORKING HOURS FOR MINORS 14 and 15 YEARS OF AGE

No person under 16 shall be employed:
1. During school hours except where specifically permitted by Chapter 4109
2. Before 7 a.m. or after 9 p.m. from June 1st to September 1st or during any school holiday of 5 school days or more; or after 7 p.m. at any other time
3. For more than 3 hours a day in any school day
4. For more than 18 hours in any school week
5. For more than 8 hours in any day when school is not in session
6. For more than 40 hours in any week that school is not in session nor during school hours, unless employment is incidental to bona fide programs of vocational cooperative training, work-study, or other work-oriented programs with the purpose of educating students, and the program meets standards established by the state board of education.

RESTRICTIONS ON WORKING HOURS FOR MINORS 16 and 17 YEARS OF AGE

No person 16 or 17 who is required to attend school shall be employed:
1. Before 7 a.m. on any day that school is in session or 6 a.m. if the person was not employed after 8 p.m. the previous night
2. After 11 p.m. on any night preceding a day that school is in session.

PROHIBITED OCCUPATIONS FOR MINORS UNDER 16 YEARS OF AGE

1. All manufacturing; mining; processing; public messenger service
2. Work in freezers and meat coolers and all preparation of meats for sale (except wrapping, sealing, labeling, weighing, pricing and stocking)
3. Transportation; storage; communications; public utilities; construction; repair
4. Work in boiler or engine rooms; maintenance or repair of machinery
5. Outside window washing from window sills or scaffolding and/or ladders
6. Cooking and baking; operating, setting up, adjusting, cleaning, oiling or repairing power-driven food slicers, grinders, food choppers, cutters, bakery type mixers
7. Loading or unloading goods to and from trucks
8. All warehouse work except office and clerical
9. Work in connection with cars and trucks involving the use of pits, racks or lifting apparatus or involving the inflation of any tire mounted on a rim equipped with a removable retaining ring.

PROHIBITED OCCUPATIONS FOR MINORS 14 through 17 YEARS OF AGE

1. Occupations involving slaughtering, meat-packing, processing or rendering
2. Power-driven bakery machines
3. Occupations involved in the manufacture of brick, tile and kindred products
4. Occupations involved in the manufacture of chemicals
5. Manufacturing or storage occupations involving explosives
6. Occupations involving exposure to radioactive substances and to ionizing radiations
7. Power-driven paper products machines
8. Power-driven metal forming, punching and shearing machines
9. Occupations involved in the operation of power-driven circular saws, band saws and guillotine shears
10. Power-driven woodworking machines
11. Coal mines
12. Occupations in connection with mining, other than coal
13. Logging and sawmilling
14. Motor vehicle occupations
15. Maritime and longshoreman occupations
16. Railroads
17. Excavation operations
18. Power-driven and hoisting apparatus
19. Roofing operations
20. Wrecking, demolition, and shipbreaking.

MINORS UNDER 16 YEARS OF AGE MAY NOT ENGAGE IN DOOR-TO-DOOR EMPLOYMENT UNLESS

The for-profit employer is REGISTERED with the Ohio Department of Commerce. DOOR-TO-DOOR SALES EMPLOYERS SHALL:
1. Be in compliance with all applicable Ohio and Federal laws relating to the employment of minors
2. Provide at least one supervisor who is over the age of eighteen, for each six minor employees
3. Have been and be in compliance with Ohio's Motor Vehicle Financial Responsibility, Workers' Compensation, Unemployment Compensation, and all other applicable laws
4. Require all minors to work at least in pairs
5. Not employ any minor who does not have an appropriate Age and Schooling Certificate
6. Provide each minor employee with a photo identification card
7. Not employ any minor in any door-to-door sales activity during school hours except where specifically permitted
8. Not employ minors under 16 in door-to-door sales activity before 7 a.m. or after 7 p.m.
9. Not employ minors 16 and 17 years of age in door-to-door sales activity before 7 a.m. or after 8 p.m.

*For Exceptions to Coverage See Chapter 4109.06

This is a summary of ORC 4109. This summary does not include all of the requirements for minor labor laws. Persons should refer to 4109 for specific requirements applicable to them. This information can be accessed through the Ohio Department of Commerce Web site at www.com.state.oh.us.

POST IN A CONSPICUOUS PLACE

For further information about Minor Labor issues, please contact: The Ohio Department of Commerce, Division of Industrial Compliance & Labor, 6606 Tussing Road, Reynoldsburg, OH 43068 phone: (614) 644-2239. TTY/TDD: 1-800-750-0750. An Equal Opportunity Employer and Service Provider (REV. 1/14/11)

NO SMOKING

To report violations call

1-866-559-OHIO (6446)

in accordance with Chapter 3794

of the Ohio Revised Code.

NOTICE TO EMPLOYEES

THIS EMPLOYER PROVIDES UNEMPLOYMENT INSURANCE COVERAGE FOR EMPLOYEES

Employees who become unemployed (or are working less than full-time) may be eligible for unemployment insurance benefits.

Apply by phone at 1-877-644-6562 (OHIOJOB) or online at http://unemployment.ohio.gov

Be prepared to provide the following information when applying:

- **Social Security number**
- **Driver's license or State ID number**
- **Names, Social Security numbers, and dates of birth of all dependent children**
- **Employer's identification notice (pay stubs or W2 form)**
- **Name and address of all other employers for whom work was performed during the past 18 months**

APPLY FOR WORK AT YOUR NEAREST OHIOMEANSJOBS CENTER

John R. Kasich
Governor

Ohio | Department of Job and Family Services

Cynthia C. Dungey
Director

JFS 55341 (Rev. 5/2016)