5/8 -2009

# CERTIFIED COPY OF ORDER

**STATE OF MISSOURI** } **ea.**
**County of Boone**

November Session of the October Adjourned **Term. 20** 09

**In the County Commission of said county, on the** 5th **day of** November **20** 09

**the following, among other proceedings, were had, viz:**

Now on this day the County Commission of the County of Boone does hereby approve the following budget revision for the Prosecuting Attorney's Office, to cover costs of trial expenses for homicide trials as well as the other jury trials scheduled between now and the end of the year:

| Department | Account | Department Name | Account Name | Decrease $ | Increase $ |
|---|---|---|---|---|---|
| 1123 | 86800 | Emergency | Emergency | 8500.00 | |
| 1262 | 84700 | Victim Witness | Witness Expense | | 6000.00 |
| 1262 | 84800 | Victim Witness | Transcripts | | 1500.00 |
| 1262 | 84600 | Victim Witness | Court Costs | | 1000.00 |

Done this 5th day of November, 2009.

Kenneth M. Pearson
Presiding Commissioner

Karen M. Miller
District I Commissioner

Skip Elkin
District II Commissioner

ATTEST:

Wendy S. Noren
Wendy S. Noren
Clerk of the County Commission

# REQUEST FOR BUDGET REVISION

## BOONE COUNTY, MISSOURI

518-2009

RECEIVED

OCT 28 2009

BOONE COUNTY AUDITOR

10/27/09
EFFECTIVE DATE

FOR AUDITORS USE

| Department | | | | | Account | | | | | Department Name | Account Name | (Use whole $ amounts) Transfer From Decrease | Transfer To Increase |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | 1 | 2 | 3 | | 8 | 6 | 8 | 0 | 0 | Emergency | Emergency | 8500.00 | |
| 1 | 2 | 6 | 2 | | 8 | 4 | 7 | 0 | 0 | Victim Witness | Witness Expense | | 6000.00 |
| 1 | 2 | 6 | 2 | | 8 | 4 | 8 | 0 | 0 | Victim Witness | Transcripts | | 1500.00 |
| 1 | 2 | 6 | 2 | | 8 | 4 | 6 | 0 | 0 | Victim Witness | Court Costs | | 1000.00 |
| | | | | | | | | | | | | | |
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Describe the circumstances requiring this Budget Revision. Please address any budgetary impact for the remainder of this year and subsequent years. (Use an attachment if necessary): **Cover costs of trial expenses in the following homicide trials; State v. William Clinch, State v. Damon Williams, State v. Horace Johnson, and State v. Grady Dortch, as well as the other jury trials scheduled between now and the end of the year.**

Do you anticipate that this Budget Revision will provide sufficient funds to complete the year? ☒YES ☐NO
If not, please explain (use an attachment if necessary):

Daniel K. Knight
**Requesting Official**

---

**TO BE COMPLETED BY AUDITOR'S OFFICE**

☑ A schedule of previously processed Budget Revisions/Amendments is attached.
☑ Unencumbered funds are available for this budget revision.
☐ Comments: AGENDA

CJ
**Auditor's Office**

**PRESIDING COMMISSIONER** | **DISTRICT I COMMISSIONER** | **DISTRICT II COMMISSIONER**

Revised 04/02

519 -2009

# CERTIFIED COPY OF ORDER

**STATE OF MISSOURI** } **ea.**
**County of Boone**

November Session of the October Adjourned **Term. 20** 09

**In the County Commission of said county, on the** 5th **day of** November **20** 09

**the following, among other proceedings, were had, viz:**

Now on this day the County Commission of the County of Boone does hereby approve the recommended classification for the position of Chief Appraiser in the Assessor's Office as exempt under the Fair Labor Standards Act (FLSA) status designations.

Done this 5th day of November, 2009.

Kenneth M. Pearson
Presiding Commissioner

ATTEST:
Wendy S. Noren
Wendy S. Noren
Clerk of the County Commission

Karen M. Miller
District I Commissioner

Skip Elkin
District II Commissioner

520-2009

# CERTIFIED COPY OF ORDER

**STATE OF MISSOURI** } **ea.**
**County of Boone**

November Session of the October Adjourned **Term. 20** 09

**In the County Commission of said county, on the** 5th **day of** November **20** 09

**the following, among other proceedings, were had, viz:**

Now on this day the County Commission of the County of Boone does hereby approve the recommended classification for the positions of Buyer and Senior Buyer in the Purchasing Office as exempt under the Fair Labor Standards Act (FLSA) status designations.

Done this 5th day of November, 2009.

Kenneth M. Pearson
Presiding Commissioner

Karen M. Miller
District I Commissioner

Skip Elkin
District II Commissioner

ATTEST:

Wendy S. Noren
Clerk of the County Commission

521 -2009

# CERTIFIED COPY OF ORDER

**STATE OF MISSOURI** } **ea.**
**County of Boone**

November Session of the October Adjourned **Term. 20** 09

**In the County Commission of said county, on the** 5th **day of** November **20** 09

**the following, among other proceedings, were had, viz:**

Now on this day the County Commission of the County of Boone does hereby approve the changes to the Family and Medical Leave Act Policy (FMLA) as proposed by the Boone County Human Resources Department.

Done this 5th day of November, 2009.

Kenneth M. Pearson
Presiding Commissioner

Karen M. Miller
District I Commissioner

Skip Elkin
District II Commissioner

ATTEST:

Wendy S. Noren
Clerk of the County Commission

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

U.S. Department of Labor
Employment Standards Administration
Wage and Hour Division

U.S. Wage and Hour Division

OMB Control Number: 1215-0181
Expires: 12/31/2011

**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 to care for a covered family member with a serious health condition to submit a medical certification issued by the health care provider of the covered family member. 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' family members, 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.

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 family member or his/her 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 to care for a covered family member with a 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 to your employer. 29 C.F.R. § 825.305.

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


CONTINUED ON NEXT PAGE

**SECTION III: For Completion by the HEALTH CARE PROVIDER**

**INSTRUCTIONS to the HEALTH CARE PROVIDER:** The employee listed above has requested leave under the FMLA to care for your patient. Answer, fully and completely, all applicable parts below. 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 patient needs leave. Page 3 provides space for additional information, should you need it. 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 patient 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 any 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 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

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.**

# Notice of Eligibility and Rights & Responsibilities (Family and Medical Leave Act)

U.S. Department of Labor
Employment Standards Administration
Wage and Hour Division


OMB Control Number: 1215-0181
Expires: 12/31/2011

In general, to be eligible an employee must have worked for an employer for at least 12 months, have worked at least 1,250 hours 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 active duty or call to active duty status in support of a contingency operation as a member of the National Guard or Reserves.

_____ 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 1,250-hours-worked 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: _____

_____

_____

____ No additional information requested


CONTINUED ON NEXT PAGE

**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 lapse, or, at our option, we may pay your share of the premiums during FMLA leave, and recover these payments from you upon your return to work.

____ 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 reverse side of 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
Employment Standards Administration
Wage and Hour Division

U.S. Wage and Hour Division

OMB Control Number: 1215-0181
Expires: 12/31/2011

**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 WH-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 not
(Provide at least seven calendar days)
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.**

# Certification of Qualifying Exigency For Military Family Leave (Family and Medical Leave Act)

U.S. Department of Labor
Employment Standards Administration
Wage and Hour Division


OMB Control Number: 1215-0181
Expires: 12/31/2011

**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 C.F.R. § 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 C.F.R. § 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 covered military member on active duty or call to active duty status in support of a contingency operation:

_____
First Middle Last

Relationship of covered military member to you: _____

Period of covered military member's active duty: _____

A complete and sufficient certification to support a request for FMLA leave due to a qualifying exigency includes written documentation confirming a covered military member's active duty or call to active duty status in support of a contingency operation. Please check one of the following:

- ☐ A copy of the covered military member's active duty orders is attached.
- ☐ Other documentation from the military certifying that the covered military member is on active duty (or has been notified of an impending call to active duty) in support of a contingency operation is attached.
- ☐ I have previously provided my employer with sufficient written documentation confirming the covered military member's active duty or call to active duty status in support of a contingency operation.


CONTINUED ON NEXT PAGE

## 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 an appointment with a counselor or school official, 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? ☐ No ☐ Yes.

   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? ☐ No ☐ Yes.

   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.


CONTINUED ON NEXT PAGE

PART C:

If leave is requested to meet with a third party (such as to arrange for childcare, to attend counseling, to attend meetings with school or childcare providers, to make financial or legal arrangements, to act as the covered 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**

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 AV, NW, Washington, DC 20210. **DO NOT SEND THE COMPLETED FORM TO THE WAGE AND HOUR DIVISION; RETURN IT TO THE EMPLOYER.**

# Certification for Serious Injury or Illness of Covered Servicemember - - for Military Family Leave (Family and Medical Leave Act)

U.S. Department of Labor
Employment Standards Administration
Wage and Hour Division


OMB Control Number: 1215-0181
Expires: 12/31/2011

**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 covered 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 C.F.R. § 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 C.F.R. § 1630.14(c)(1), if the Americans with Disabilities Act applies.

**SECTION I: For Completion by the EMPLOYEE and/or the COVERED SERVICEMEMBER for whom the Employee Is Requesting Leave** **INSTRUCTIONS to the EMPLOYEE or COVERED 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 covered 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 C.F.R. § 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; or (3) a DOD non-network TRICARE authorized private health care provider** **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 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 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 covered servicemember's serious injury or illness includes written documentation confirming that the covered servicemember's injury or illness was incurred in the line of duty on active duty and that the covered 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 condition for which the employee is seeking leave.

# Certification for Serious Injury or Illness of Covered Servicemember - - for Military Family Leave (Family and Medical Leave Act)

U.S. Department of Labor
Employment Standards Administration
Wage and Hour Division

U.S. Wage and Hour Division

**SECTION I: For Completion by the EMPLOYEE and/or the COVERED 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 covered servicemember):

_____

Name of Employee Requesting Leave to Care for Covered Servicemember:

_____
First Middle Last

Name of Covered Servicemember (for whom employee is requesting leave to care):

_____
First Middle Last

Relationship of Employee to Covered Servicemember Requesting Leave to Care:
☐ Spouse ☐ Parent ☐ Son ☐ Daughter ☐ Next of Kin

**Part B: COVERED SERVICEMEMBER INFORMATION**

(1) Is the Covered Servicemember a Current Member of the Regular Armed Forces, the National Guard or Reserves? ☐ Yes ☐ No

If yes, please provide the covered servicemember's military branch, rank and unit currently assigned to:

_____

Is the covered 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 Covered Servicemember on the Temporary Disability Retired List (TDRL)? ☐ Yes ☐ No

**Part C: CARE TO BE PROVIDED TO THE COVERED SERVICEMEMBER**

Describe the Care to Be Provided to the Covered 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; or (3) a DOD non-network TRICARE authorized private health care provider. 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; or (4) a DOD non-network TRICARE authorized private health care provider: _____

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

PART B: MEDICAL STATUS

(1) Covered 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 or an employer-provided form seeking the same information.)

(2) Was the condition for which the Covered Service member is being treated incurred in 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 covered servicemember undergoing medical treatment, recuperation, or therapy? ☐ Yes ☐ No. If yes, please describe medical treatment, recuperation or therapy:

PART C: COVERED SERVICEMEMBER'S NEED FOR CARE BY FAMILY MEMBER

(1) Will the covered 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 covered servicemember require periodic follow-up treatment appointments?
☐ Yes ☐ No If yes, estimate the treatment schedule: _____

(3) Is there a medical necessity for the covered servicemember to have periodic care for these follow-up treatment appointments? ☐ Yes ☐ No

(4) Is there a medical necessity for the covered 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**

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# Glossary of Key Terms under the Family and Medical Leave Act and Related Statutes

**Active duty/call to active duty** — This term means a duty under a call or order to active duty (or notification of an impending call or order to active duty) in support of a military contingency operation.

**Adoption** — Adoption occurs when an adult legally and permanently assumes the responsibility for raising a non-biological child as one's own.

**COBRA** — The continuation health care provisions of the Employee Retirement Income Security Act that were enacted as part of the Consolidated Omnibus Budget Reconciliation Act of 1985 are referred to generally as COBRA. COBRA covers group health plans of employers with 20 or more employees and permits participants and beneficiaries who experience a qualifying event to maintain at their own expense coverage under their employer's health plan at a cost that is comparable to what it would be if they were still members of the employer's group. Qualifying events triggering COBRA coverage include loss of coverage under the plan due to death, termination, reduced hours of employment, entitlement to Medicare, or bankruptcy.

**Contingency operation** — This is a military operation that (1) is designated by the secretary of Defense as an operation in which members of the armed forces are or may become involved in military actions, operations, or hostilities against an enemy of the United States or against an opposing military force; or (2) results in the call or order to, or retention on, active duty of members of the uniformed services.

**Covered military member** — An employee's spouse, son, daughter, or parent on active duty or call to active duty status is a covered military member.

**Covered servicemember** — A covered servicemember is a current member of the Armed Forces, including a member of the National Guard or 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 incurred in the line of duty on active duty.

**Economic Harm** — It is not whether the employee's absence would cause the employer injury, but whether restoration of employment at the end of leave would do so. In making its determination, the employer may take into account its ability to replace or temporarily do without the employee. If permanent replacement is unavoidable, the cost of reinstating the employee to an equivalent position may be considered.

**Eligible employee** — An eligible employee is one who has been employed for a total of at least 12 months by the employer as of the date on which any FMLA leave is to commence, except that an employer need not consider any period of previous employment that occurred more than seven years before the date of the most recent hiring of the employee, unless the break is caused by the fulfillment of employee's National Guard or Reserve military service obligation (the time served performing the military service must be also counted in determining whether the employee has been employed for at least 12 months by the employer), or a written agreement, including a collective bargaining agreement, that denotes the employer's intention to rehire the employee after the break in service (e.g., for purposes of the employee furthering his or her education or for childrearing purposes); and who, on the date on which any FMLA leave is to commence, has been employed for at least 1,250 hours of service with such employer during the previous 12-month period, except that an employee returning from fulfilling his or her National Guard or Reserve military obligation shall be credited with the hours-of-service that would have been performed but for the period of military service in determining whether the employee worked the 1,250 hours of service; and who is employed in any state of the United States, the District of Columbia or any territories or possession of the United States.

**Employer** — An employer under the FMLA is any "person" engaged in commerce or in any industry or activity affecting commerce that employs 50 or more employees for each working day during each of 20 or more calendar workweeks in the current or preceding calendar year; any public agency as defined under the Fair Labor Standards Act; or local educational agencies and private elementary and secondary schools.

**Employment benefits** — These include all benefits provided or made available to employees by an employer, including group life insurance, health insurance, disability insurance, sick leave, annual leave, educational benefits or pensions.

**Equivalent position** — An equivalent position is one that is virtually identical to the employee's former position in terms of pay, benefits and working conditions, including privileges and status. It must involve the same or substantially similar duties and responsibilities, which must entail substantially equivalent skill, effort, responsibility and authority.

**Family member** — A spouse, child or parent of an eligible employee is a family member under the FMLA.

**Foster care** — Foster care occurs when an adult assumes the 24-hour care for a non-biological child in substitution for the child's parents or guardians.

**Health care provider** — A health care provider as defined by the FMLA is a doctor of medicine or osteopathy who is authorized to practice medicine or surgery by the state in which he or she practices and anyone determined by the secretary of Labor to be capable of providing health care services will also qualify as a health care provider. Included are: (1) podiatrists, dentists, clinical psychologists, optometrists, and chiropractors (limited to treatment consisting of manual manipulation of the spine to correct a subluxation as demonstrated by X-ray to exist) authorized to practice in the state; (2) nurse practitioners, clinical social workers, physicians assistants and midwives who are authorized to practice in the state; (3) Christian Science practitioners listed with the First Church of Christ, Scientist in Boston; (4) any health care provider from whom an employer or the employer's group health plan's benefits manager will accept certification of the existence of a serious health condition to substantiate a claim for benefits; and (5) a health care provider listed above who practices in a country other than the United States, who is authorized to practice in accordance with the law of that country.

**In loco parentis** — Those persons with day-to-day responsibilities to care for and financially support a child or, in the case of an employee, who had such responsibility for the employee when the employee was a child, are in the status of *in loco parentis.* A biological or legal relationship is not necessary.

**Inpatient care** — Inpatient care is an overnight stay in a hospital, hospice, or residential medical care facility, including any period of incapacity, or any subsequent treatment in connection with such inpatient care.

**Intermittent leave** — Intermittent leave is leave taken in separate periods of time due to a single illness or injury, rather than for one continuous period of time, and may include leave of periods from an hour or more to several weeks. Examples of intermittent leave would include leave taken on an occasional basis for medical appointments, or leave taken several days at a time spread over a period of six months, such as for chemotherapy.

**Key employee** — For FMLA purposes, a key employee is a salaried eligible employee who is among the highest paid 10 percent of employees who work within 75 miles of the facility where the employee taking leave is employed. In order to deny restoration to a key employee, an employer must determine that the restoration of the employee to employment will cause substantial and grievous economic injury.

**Light duty** — If an employee is injured on the job and is not able to perform the essential functions of his or her regular position, he or she may accept a light-duty position, which is lesser or more sedentary than his or her regular position. The time the employee spends on light duty does not count against his or her FMLA leave entitlement, but the employee may remain in the light-duty position only up to the conclusion of the 12-month leave period.

**Medical certification** — An employee who requests leave because of a serious health condition or to care for a spouse, child, or parent with a serious health condition, may be required to support the leave request with a medical certification issued by a health care provider. A certification must include the date on which the serious health condition began, its probable duration, and the relevant medical facts within the knowledge of the health care provider for which the employee seeks leave, such as symptoms, diagnosis or any regimen of continuing treatment, such as the use of specialized equipment.

**Military caregiver leave** — An eligible employee who is the spouse, son, daughter, parent or next of kin of a covered servicemember can take up to 26 workweeks of job-protected military caregiver leave during a single 12-month period to care for the servicemember.

**Military family leave** — This is a term for leave provided under the FMLA for eligible employees with a spouse, son, daughter or parent called to active duty status in the National Guard, Reserves or certain retired members of the Armed Forces in support of a contingency operation. Covered military members may use their 12-week leave entitlement to address certain qualifying exigencies. This leave also permits military members and next of kin to take up to 26 weeks of leave to care for a covered servicemember during a single 12-month period.

**Needed to care for** — This term encompasses both physical and psychological care for a family member or covered servicemember. It includes situations where, for example, because of a serious health condition, the family member or covered servicemember is unable to care for his or her own basic medical, hygienic, or nutritional needs or safety, or is unable to transport himself or herself to the doctor. The eligible employee can take intermittent or reduced schedule leave for these situations, not only if the health condition itself is intermittent but if the employee is only needed intermittently, such as when someone else is available to provide care.

**Next of kin** — Next of kin of a covered servicemember is the nearest blood relative other than the covered servicemember's spouse, parent, son, or daughter, in the following order of priority: blood relatives who have been granted legal custody of the covered servicemember by court decree or statutory provisions, brothers and sisters, grandparents, aunts and uncles, and first cousins, unless the covered servicemember has specifically designated in writing another blood relative as his or her nearest blood relative for purposes of military caregiver leave under the FMLA. When no such designation is made, and there are multiple family members with the same level of relationship to the covered servicemember, all such family members shall be considered the covered servicemember's next of kin and may take FMLA leave to provide care to the covered servicemember, either consecutively or simultaneously.

**Outpatient status** — Outpatient status means the status of a member of the Armed Forces assigned to either a military medical treatment facility as an outpatient or a unit established for the purpose of providing command and control of members of the Armed Forces receiving medical care as outpatients.

**Parent** — Under the FMLA, a parent is the biological, adoptive, step or foster parent or any other individual who stood *in loco parentis* to an employee when the employee was a son or daughter. This includes an individual who assumes "day-to-day" responsibility for a child, such as a grandparent.

**Parent of a covered servicemember** — This term means a covered servicemember's biological, adoptive, step or foster father or mother, or any other individual who stood in loco parentis to the covered servicemember. This term does not include parents "in law."

**Permanent or long-term conditions** — These conditions include periods of incapacity that are permanent or long-term due to a condition for which treatment may not be effective. The employee or family member must be under the continuing supervision of, but need not be receiving active treatment by, a health care provider. Examples include Alzheimer's, a severe stroke, or the terminal stages of a disease.

**Public employer** — Public employers include the government of the United States; the government of a state or a political subdivision of a state; any agency of the United States (including the U.S. Postal Service and Postal Rate Commission); or any interstate governmental agency. Public employers are covered employers regardless of the number of employees they have. However, they only have to grant leave to employees who work at a site with 50 or more employees within a 75-mile radius.

**Qualifying exigency** — Eligible employees can take leave for a qualifying exigency when their spouse, son, daughter or parent is called to active military service. The purpose of this leave is to assist servicemembers' families in managing their affairs while the servicemember is on active duty. Only families of servicemembers in the Reserves, National Guard and certain retired members of the Armed Forces are covered by this provision. Qualifying exigencies may include attending certain military events, arranging for alternative childcare, addressing certain financial and legal arrangements, attending certain counseling sessions, and attending post-deployment reintegration briefings.

**Recertification** — Employers who are unsure whether an employee's original medical certification currently accurately reflects the validity of the worker's serious health condition may request a recertification of that health condition. An employer generally may not request a recertification more frequently than every 30 days. If the original certification indicates that the minimum duration of the incapacity will be for more than 30 days, the employer must wait until that time has passed before requesting a recertification. Only if the employee requests an extension of leave, or circumstances have changed significantly, such as the nature of the illness or duration or frequency of the absences, may the employer request recertification in fewer than 30 days. The employer may ask for a recertification at any time if it has reason to doubt the employee's veracity.

**Reduced schedule leave** — A reduced schedule leave is leave that reduces an employee's usual number of working hours per workweek, or hours per workday. A reduced leave schedule is a change in the employee's schedule for a period of time, normally from full-time to part-time.

**Regimen of continuing treatment** — A regimen of continuing treatment includes a course of prescription medication or therapy requiring special equipment to resolve or alleviate the health condition. Taking aspirin, bed rest and drinking fluids, or other similar regimens of treatment that do not need to be prescribed by a health care provider are not, by themselves, included.

**Serious health condition** — This is an illness, injury, impairment, or physical or mental condition that involves inpatient care or continuing treatment by a health care provider. The "continuing treatment" test for a serious health condition under the regulations may be met through (1) a period of incapacity of more than three consecutive, full calendar days plus treatment, (2) any period of incapacity related to pregnancy or for prenatal care, (3) any period of incapacity or treatment for a chronic serious health condition, (4) a period of incapacity for permanent or long-term conditions for which treatment may not be effective, or (5) any period of incapacity to receive multiple treatments (including recovery from those treatments) for restorative surgery, or for a condition which would likely result in an incapacity of more than three consecutive, full calendar days absent medical treatment.

The regulations specify that if an employee asserts a serious health condition under the requirement of a "period of incapacity of more than three consecutive, full calendar days and any subsequent treatment or period of incapacity relating to the same condition," the employee's first treatment visit (or only visit, if coupled with a regimen of continuing treatment) must take place within seven days of the first day of incapacity. Additionally, if an employee asserts that the condition involves "treatment two or more times," the two visits to a health care provider must occur within 30 days of the first day of incapacity. Finally, the regulations define "periodic visits" for treatment of a chronic serious health condition as at least twice a year.

**Seriously injured or ill servicemember** — This is a servicemember who has an injury or illness incurred in the line of duty on active duty that may render him or her medically unfit to perform the duties of the member's office, grade, rank or rating.

**Servicemember** — An employee's spouse, son, daughter or parent on military active duty or call to active duty status is a servicemember.

**Son or daughter** — This can be a biological, adoptive, or foster child, a stepchild, a legal ward, or a child of a person standing *in loco parentis,* who is (1) under 18 years of age, (2) 18 years or older and incapable of self care because of a mental or physical disability, or for purposes of military family leave, of any age.

**Son or daughter of a covered servicemember** — This terms means the servicemember's biological, adopted, or foster child, stepchild, legal ward, or a child for whom the servicemember stood *in loco parentis,* and who is of any age.

**Son or daughter on active duty or call to active duty status** — This term means the employee's biological, adopted, or foster child, stepchild, legal ward, or a child for whom the employee stood *in loco parentis,* who is on active duty or call to active duty status, and who is of any age.

**Spouse** — A husband or wife as defined or recognized under state law for purposes of marriage, including common law marriage in states where it is recognized. The definition is intended to make clear that an employer does not have to grant an employee family or medical leave to care for an unmarried domestic partner.

**Treatment** — Treatment by a health care provider means examinations to determine if a serious health condition exists and evaluations of the condition, but is not limited to just that. It does not include routine physical, eye or dental examinations.

**Undue hardship** — An undue hardship is an action requiring significant difficulty or expense for an employer when considered in light of factors such as an employer's size, financial resources, and the nature and structure of its operation.

**Worksite** — A worksite is the single site or a group of contiguous locations to which an employee is assigned or to which he or she reports.

## 5.1: Family and Medical Leave Act Policy:

The Family and Medical Leave Act (FMLA) recognizes that there are times when an employee must cease working temporarily due to personal illness, a family member's illness or other family responsibilities. Through the enactment of the FMLA the United States Congress established a minimum labor standard to balance the demands of the workplace with the needs of families. The FMLA entitles eligible employees to job protected leave in certain circumstances.

**1. Eligible Employees**

To be eligible for Family and Medical Leave Act leave, an employee must:

a) Have been employed by the County for at least 12 months (need not be continuous); and

b) Have at least 1,250 hours in pay status during the 12-month period immediately preceding the leave (unless absent for military caregiver leave).

**2. Policy**

Under this policy, the County provides eligible employees with:

a) Up to 12 work weeks of unpaid, job-protected leave in a single, 12 month period for certain family and medical reasons, or

b) Up to 26 workweeks of unpaid, job-protected leave in a single, 12 month period for eligible employees to care for a covered service member with a serious illness or injury, as specified in the County's Military FMLA Policy. In general, Military FMLA issues are addressed in Section 5.1(a) Military Family and Medical Leave Policy.

**3. Reasons for Leave**

Eligible employees can take leave for any of the following reasons:

- the birth of an employee's child, and care for the newborn child;

- the placement of a child with the employee for adoption or foster care;
- because of a serious health condition that makes the employee unable to perform the functions of the employee's job;

- to care for the serious health condition of the employee's child, spouse or parent;

- because of certain family and medical events as specified in the Military FMLA Policy.

**4. Notice of Leave**

If the need for FMLA leave is foreseeable, the employee must give the County at least 30 days prior written notice. Where the need for FMLA leave is not foreseeable, the employee is expected to notify the County as soon as is practical. When an employee becomes aware of a need for FMLA leave less than 30 days in advance, it should be practicable for the employee to provide notice of the need for leave either the same day or the next business day.

The employee must comply with the usual and customary notice provisions for leave in place at each facility.

**Substitution of Paid Leave:**

A. The Administrative Authority of employees who request leave under FMLA for their own serious health condition or for the serious health condition of a family member may substitute accrued sick leave for unpaid leave provided that it meets those conditions outlined in the sick leave policy. {See Section 2.6: Sick Leave.} After sick leave has been exhausted, the Administrative Authority of employees may substitute accrued vacation leave for unpaid leave. Any use of approved paid leave runs concurrently with FMLA and is not considered a substitution for FMLA leave time.

B. Employees who request leave under the FMLA for placement of a child with the employee for adoption or foster care may substitute accrued sick leave or vacation for unpaid leave with the approval of the Administrative Authority.

C. When an employee substitutes paid leave for unpaid leave, and the substituted paid leave is less than twelve (12) weeks in duration, the Administrative Authority will provide an additional period of unpaid leave so that the total of paid leave and unpaid leave provided equals not more than twelve (12) weeks during any twelve (12) month period. The twelve (12) month period is measured forward from the date the employee first begins using FMLA time.

## 5. Eligibility Notice/Rights and Responsibilities

The County will provide employees who request FMLA leave with a notice of their eligibility for the leave or a reason why they are not eligible within five (5) business days of the leave request. At the same time, employees will be provided with a statement of their Rights and Responsibilities using form WH-381, Notice of Eligibility and Rights and Responsibilities. The relevant Medical Certification form will also be given to the employee at this time (see next section, #6). Forms are available from Human Resources or your supervisor.

**Exception for Key Employees:**
Because of the potential substantial and grievous economic injury that can occur when top-level executives are absent for several weeks, "key" employees may take FMLA leave but are not guaranteed the same rights to job restoration as other eligible workers. The determination of whether an employee is a key employee who is among the county's highest paid top 10 percent is made at the time the employee requests leave. The County is required to give key employees two types of notice: (1) that they are key employees, and, if the County determines that restoration would cause sufficient economic harm, (2) that the employee might be denied job restoration. Contact Human Resources if you are unsure whether the affected employee falls in this category.

## 6. Medical Certification is Required

Employees who request FMLA leave because of their own or a family member's serious health condition must submit a Medical Certification Form completed by the health care provider to support the leave request. If the leave is due to the employee's own serious health condition, form WH-380-E Certification of Health Care Provider for Employee's Serious Health Condition must be completed and returned to your supervisor. If the leave is due to a family member's serious health condition, form WH-380-F Certification of Health Care Provider for Family Member's Serious Health Condition must be completed and returned to your supervisor. These forms are available from Human Resources or your supervisor. The Medical Certification Form should be returned to the County within 15 calendar days after it is requested, or as soon as possible under the circumstances.

If the Medical Certification Form returned to the County is not satisfactory, an employee will be told of the deficiencies in writing and given seven (7) days to complete the form. Failure to submit a complete and sufficient Medical Certification will be grounds for, and may result in, deferral or denial of the requested FMLA leave.

If the medical information is inadequate, County representatives other than the employee's direct supervisor (i.e., HR professional, management official) may contact the employee's health provider directly to authenticate or clarify information on the certification without the employee's consent. If more complete information is needed regarding the nature of the health condition, the duration of leave, the need for intermittent leave, etc., the County representatives (other than direct supervisor) may directly contact the employee's health care provider after receiving the employee's Medical Information Release Form. A Medical Information Release Form is available from Human Resources or your supervisor.

The County can request a second or third opinion regarding the employee's condition and treatment (at the County's expense). In the event of a conflict between the first and second opinions, the County may at its own expense, obtain a third opinion from a health care provider approved jointly by the County and the employee. This third opinion will be final and binding.

All employees requesting an extension of any FMLA leave must provide a new Medical Certification (or its equivalent) of the need for continuing leave.

**7. Designation Notice**

Within five (5) business days (absent extenuating circumstances) of having enough information to determine whether the leave is FMLA eligible, the County will provide a Designation Notice Form WH-382 informing the employee whether or not leave is designated as FMLA leave and the amount of leave that will be designated, if known. This designation may be retroactive.

Employees absent on medical leave for their own serious health condition will be required to provide medical certification of their fitness to return to work. If necessary, the Elected Official/Department Director may furnish to the physician or may attach to the designation notice a description of the job duties, including any physical requirements. Employees failing to provide the fitness-for-duty certification based on these essential job functions cannot resume work until such certification is provided. A Fitness for Duty Certification Form is available from Human Resources or your supervisor.

In the sole discretion of the County, any leave that qualifies as FMLA Leave may be designated as FMLA leave. For example, the County may designate leave as FMLA leave without requiring a complete Medical Certification or a consultation with a health care provider.

## 8. Duration of Family and Medical Leave

Eligible employees will be entitled to up to a cumulative maximum of 12 workweeks of FMLA leave within a 12 month period unless leave is for a covered service member's care for which up to 26 workweeks are provided. Any combination of FMLA leave may not exceed the maximum of 26 workweeks in any single twelve (12) month period.

To determine eligibility, the 12 month period is measured backwards from the date an employee's requested FMLA leave begins. The FMLA leave year will begin on the first day that the employee takes FMLA leave.

A husband and wife who both work for the County are entitled to a combined total of 12 weeks leave in a 12-month period for the birth, adoption, or foster care placement of their child, or to care for a parent with a serious health condition. Both the mother and father are entitled to 12 workweeks of leave to care for a seriously ill child.

In certain cases, leave may be taken on an intermittent basis or the employee may work a reduced schedule. Intermittent leave must be certified by a health care provider as necessary and should be scheduled to avoid disruption insofar as is reasonable.

A. In the case of a serious health condition of an employee or a family member, when medically necessary, leave may be taken on a reduced leave schedule or intermittently.

B. Unless the Administrative Authority and the employee agree otherwise, leave taken for the birth or adoption of a son or daughter cannot be taken on a reduced leave schedule or intermittently.

C. Employees requesting intermittent or reduced schedule leave based on planned medical treatment may be required to produce medical certification outlining the dates and duration of treatment. A reasonable effort must be made, subject to the health care provider's approval, to schedule treatment so as to not unduly disrupt the County's operations. An employee must give 30 days notice, or as much notice as practicable of his/her intentions. The Administrative Authority may require an employee who requested foreseeable intermittent or reduced schedule leave due to planned medical treatment to transfer temporarily to an available alternative position if:

    1) The employee is qualified for the alternative position,
    2) The position has equivalent pay and benefits, and

3) The alternative position better accommodates recurring periods of leave than the employee's regular position.

**9. Recertification**

An employee may be asked to recertify a serious health condition every 30 days (if the employee is absent during that period) for chronic/long-term illness or pregnancy. A recertification may be requested in fewer than 30 days, if:

- the employee ask for extensions of leave;
- the circumstances have changed; or
- the County has doubts about the employee's FMLA status (e.g., Monday/Friday absences).

Employees will be required to have **annual** medical certifications for their own serious health condition lasting more than one year, including chronic/lifelong ailments.

**10. Return to Work**

Employees returning to work from FMLA leave will be returned to the same or an equivalent position held prior to the leave, unless the position has ceased to exist because of business necessity. If the employee does not return to his or her original position or an equivalent one as soon as he is able, the County will consider the employee to have voluntarily resigned.

Certain "key" employees may not be eligible to be reinstated to the same or an equivalent position at the conclusion of their FMLA leave. Any employee in the highest paid ten (10) percent of the County's workforce may be denied restoration to their position or an equivalent position at the conclusion of FMLA if certain criteria are met. The County will notify such employees of their "key employee" status and the conditions under which they may denied reinstatement, if applicable.

**11. Employee Benefits**

The following information applies if the employee is on Family and Medical Leave:

*A. Insurance Benefits Remain Intact:* An employee granted an FMLA leave will continue to be covered under the County's group health and life insurance plans under the same conditions as coverage would have been provided if they had been continuously employed during the leave period.

*B. Employee Contributions Required:* Employee contributions will be required either by payroll deduction or direct payment, in advance, to the County for all insurance costs not normally paid by the County. Employee contribution amounts are subject to any rate changes that occur while the employee is on leave.

*C. Coordination of Paid Benefits:* If paid sick and/or vacation is used to supplement any payments that an employee is eligible to receive, the combination of any such disability payments, worker's compensation, paid sick and/or vacation leave can not exceed the employee's regular hourly rate for a 40 hour work week.

*D. End of County Obligations:* The obligation to maintain insurance benefits ends when an employee reports intent not to return to work at the end of the leave period, or if the employee fails to return to work after the Family Medical Leave entitlement is exhausted; or if the employee fails to pay insurance costs not normally paid by the County.

**12. Complaints and Enforcement:**

If an employee requests and is denied Family Medical Leave, the employee may file a grievance directly with the Administrative Authority. Employees may contact the Human Resources Director regarding any complaints or to obtain information on their rights and responsibilities under the FMLA.

The U.S. Department of Labor has legal authority and is required to receive, conduct investigations, and attempt to resolve complaints and to ensure compliance with Title I of the Family and Medical Leave Act.

The County must make, keep and preserve records pertaining to their compliance with the general requirements for family and medical leave. These records can be subpoenaed. All employee's medical information must be stored in a separate file from the employee's personnel file.

Revised 11/5/09

## 5.1 (a) Military Family and Medical Leave Act Policy

### 1. Eligible Employees

An employee who is eligible to take leave under the Family and Medical Leave Act (FMLA) may be eligible for military family leave under the 2008 amendments to the law if:

1) You have "any qualifying exigency" arising out of the fact that your spouse, son, daughter, or parent is on active duty, or has been notified of an impending call to active duty status, in support of contingency operation; OR

2) You are a spouse, son, daughter, parent or next of kin of a covered service member, who is recovering from a serious illness or injury sustained in the line of duty on active duty, in order to care for the service member.

### 2. Policy

Under the military FMLA policy, there are two types of leave available:

a) Under the "active duty" leave, Boone County will grant you leave for up to twelve (12) workweeks of unpaid, job-protected leave in a 12 month period because of a qualifying exigency; OR

b) Under the "military caregiver" provisions, Boone County will grant military caregiver leave for up to 26 weeks of unpaid, job-protected leave in a single twelve (12) month period to care for a covered service member with a serious illness or injury.

Unless specifically stated otherwise, procedures, notices and rights and responsibilities stated above as part of the County policy for traditional FMLA apply to military FMLA.

### 3. Reasons for Leave

Eligible employees can take leave for any of the following reasons:

- because of any qualifying exigency arising out of the fact that a son, daughter, spouse, or parent of the employee is on active duty (or has been notified of an impending call or order to active duty) in the Armed Forces in support of a contingency operation. **This leave is limited to relatives of National Guard and Reserve service members and of Armed Forces retirees who are in federal service.**

- to care for a covered service member with a serious injury or illness if the employee is the spouse, son, daughter, parent, or next of kin (nearest blood relative) of the covered service member. **This leave does not cover relatives of veterans or service members on the permanent disability list.**

**4. Who is a Covered Service Member?**

A covered service member is one who is undergoing medical treatment, recuperation, or therapy, who is otherwise in outpatient status, or is otherwise on the temporary disability retired list, for a serious injury or illness. The serious injury or illness is covered if incurred while in the line of duty and renders the service member medically unfit to perform his/her military duties. The County will rely on authorized health care providers or designated officials of the Department of Defense to determine whether the service member is deemed a covered service member.

**5. Notice of Leave**

When the need for leave because of a qualifying exigency related to a family member's active duty is "foreseeable," the employee should provide notice as soon as practicable, regardless of how far in advance such leave is foreseeable. When an employee becomes aware of the need for FMLA leave less than 30 days in advance, it should be practicable for the employee to provide notice of the need for leave either the same day or the next business day.

When military caregiver leave is requested, as with traditional FMLA, an employee must provide the County at least 30 days advance notice before FMLA leave is to begin if the need for the leave is foreseeable. If 30 days is not practicable, notice must be given as soon as practicable.

**6. Eligibility & Designation Notice**

Employees will receive the same Eligibility Notice and Notice of Rights and Responsibilities when requesting military FMLA leave as is given under traditional FMLA. The County will provide employees who request military FMLA leave with the appropriate certification form for Qualifying Exigency Leave or Military Caregiver Leave at this time. The Eligibility Notice/Rights and Responsibilities Notice is available from Human Resources or your supervisor.

Within five (5) business days (absent extenuating circumstances) of having enough information to determine whether the leave is FMLA eligible, the County will provide a Designation Notice Form WH-382 informing the employee whether or not leave is designated as FMLA leave

and the amount of leave that will be designated, if known. This designation may be retroactive. In the sole discretion of the County, any leave that qualifies as FMLA Leave may be designated as FMLA leave.

**7. Certification for Leave Taken Because of a Qualifying Exigency**

The first time an employee requests leave because of a qualifying exigency, the employee must provide a copy of the covered military member's active duty orders or other documentation issued by the military indicating that the covered military member is on active duty or called to active duty status in support of contingency operations, and the dates of the covered military member's active duty service. The employee will need to supply such documentation again only for a different active duty or call to active duty status of the same or a different covered service member.

A Certification Form for Qualifying Exigency Leave is available from Human Resources or your supervisor; it includes a list of approved qualifying exigencies. A completed Certification form is required to be granted this leave.

The County also may contact an appropriate unit of the Department of Defense to request verification that a covered service member is on active duty or call to active duty status, without the employee's permission.

The County may require confirmation of the employee's relationship with the service member at any time is in this process.

**8. Certification for Military Caregiver Leave**

When an employee takes leave to care for a covered service member with a serious injury or illness, the County will require the employee to obtain a certification completed by an authorized health care provider of the covered service member. A Certification for Military Caregiver Leave Form is available from Human Resources. Except as stated above, a completed form is required to be granted this leave. The County may require confirmation of the employee's relationship with the covered service member at any time in this process.

In lieu of any certification, the County will accept "invitational travel orders" ("ITOs") or "invitational travel authorizations" ("ITAs") issued to any family member to join an injured or ill service member at his or her bedside, regardless of whether the employee is named in the order or authorization. An ITO or ITA is sufficient certification for the duration of the time specified in the ITO or ITA. During that time period, an eligible

employee may take leave to care for the covered service member in a continuous block of time or on an intermittent basis.

The County may seek authentication and clarification of the ITO or ITA but will not seek a second or third opinion or a recertification during the period of time in which leave is supported by an ITO or ITA.

If an employee will need leave to care for a covered service member beyond the expiration date specified in the ITO or ITA, the County will request that the employee have one of the authorized health care providers complete a certification form for the additional time. Timelines designated under the traditional FMLA policy will apply for return of such certifications.

In all instances in which certification is requested, it is the employee's responsibility to provide the County with complete and sufficient certification and failure to do so may result in the delay or denial of FMLA leave.

The County may seek authentication and/or clarification of the Certification Form but will not seek second and third opinions, or recertification for this military FMLA leave.

**9. Duration of Military Family and Medical Leave**

Eligible employees using qualifying exigency leave will be entitled to up to a cumulative maximum of 12 workweeks of FMLA leave within a 12-month period and are covered by the same policy provisions (as to Duration, Benefits, Return to Work, etc.) as employees requesting traditional FMLA leave, as detailed above.

Employees using military caregiver leave alone or military caregiver leave in combination with traditional FMLA-qualifying leave or qualifying exigency leave, may take up to 26 workweeks of leave during any single 12-month period. The amount of leave taken for traditional and qualifying exigency is limited to a total of 12 workweeks; the difference may be taken as military caregiver leave. Any combination of FMLA leave may not exceed the maximum limit of 26 workweeks in that single 12-month period. Unused military caregiver leave is forfeited at the end of that 12-month period.

With regard to military caregiver leave, if both a husband and wife work for the County, a husband's and wife's leave is limited to a combined total of 26 workweeks for military caregiver leave alone. The same 26-workweeks limitation applies when in combination with any other 12-workweek FMLA leave. (With the exception of caring for a seriously ill

child that provides each parent with 12 workweeks of leave for a combined total of 24).

In certain cases, leave may be taken on an intermittent basis or the employee may work a reduced schedule. Intermittent leave must be necessary and should be scheduled to avoid disruption insofar as is reasonable.

(11/5/09)

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

U.S. Department of Labor
Employment Standards Administration
Wage and Hour Division

OMB Control Number: 1215-0181
Expires: 12/31/2011

**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.

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. 20 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. Please be sure to sign the form on the last page.

Provider's name and business address: _____

Type of practice / Medical specialty: _____

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


CONTINUED ON NEXT PAGE

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? ____No ____Yes.

   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.

_____

_____

_____

_____

_____

_____

**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.**

**BOONE COUNTY GOVERNMENT**
801 E. WALNUT
COLUMBIA, MO 65201

# FMLA
# RETURN TO WORK
# FITNESS FOR DUTY MEDICAL CERTIFICATION

| **EMPLOYEE:** PLEASE FILL OUT THE TOP PORTION, AND TAKE THIS FORM TO YOUR HEALTH CARE PROVIDER. THIS CERTIFICATION MUST BE PROVIDED TO YOUR DEPARTMENT PRIOR TO YOUR RETURN TO WORK. | |
|---|---|
| Employee: | |
| Employee's Department: | |
| Department Address: | |
| Department Contact: | |
| Telephone Number: | Fax Number: |

| **HEALTH CARE PROVIDER:** PLEASE COMPLETE THE FOLLOWING AND RETURN DIRECTLY TO THE DEPARTMENT LISTED ABOVE PRIOR TO THE RETURN TO WORK DATE. |
|---|
| Please review the attached job description. Is the employee able to perform all the functions of his or her job?<br>☐ Yes ☐ No ☐ Yes, with restrictions. |
| Please list any restrictions or functional limitations which the department should consider: |
| Are the restrictions: ☐ Permanent ☐ Temporary, until (date): |
| Comments |
| Employee is released to return to work effective (date): |
| _____ Signature of Health Care Provider _____ Date |
| Name of Health Care Provider: |
| Address: |
| Telephone Number: |

522 -2009

# CERTIFIED COPY OF ORDER

**STATE OF MISSOURI** } **ea.**
**County of Boone**

November Session of the October Adjourned **Term. 20** 09

**In the County Commission of said county, on the** 5th **day of** November **20** 09

**the following, among other proceedings, were had, viz:**

Now on this day the County Commission of the County of Boone does hereby approve the request to establish pay range 67 for a new Director's Position with class code # 1060. This will occur when the Design and Construction Division transfers under the Planning and Building Inspection Director. Exact job title of the Director and position code # to be established at a later date.

Done this 5th day of November, 2009.

Kenneth M. Pearson
Presiding Commissioner

ATTEST:
Wendy S. Noren
Wendy S. Noren
Clerk of the County Commission

Karen M. Miller
District I Commissioner

Skip Elkin
District II Commissioner

# Boone County Human Resources

**BETTY DICKNEITE**
Director

601 E. Walnut-Room 211
Columbia, MO 65201
(573) 886-4395

October 28, 2009

**TO:** Ken Pearson, Presiding Commissioner
Karen Miller, District 1 Commissioner
Skip Elkin, District 2 Commissioner

**FROM:** Betty Dickneite, Chairperson
Job Classification Committee

**RE:** Recommendation from Job Classification Committee

The Job Classification Committee met on October 28, 2009 to review and discuss the attached Request for a New Pay Range for the Director of the Planning & Building Inspection Department due to the transfer of the Design & Construction Division to this Department. The Job Classification Committee members unanimously* agreed to bring forward the following recommendation to the Commission:

**Establish this position on pay range 67**. The exact position title and effective date of this action to be determined by the Commission. It is recommended that we establish a new class code number of **1060** for this position.

Should you have any questions, please let me know.

Attachment

*Job Classification Committee Members present – Ken Pearson, June Pitchford, Dwayne Carey, Wendy Noren and Betty Dickneite.

# REQUEST FOR NEW PAY RANGE
# BOONE COUNTY

*Description of form: to reassign a current position pay range within the department.*
*Procedure:*
1. The Administrative Authority or designee completes the form and attaches a completed **Position Description Questionnaire** as supporting documentation and submits both forms to Human Resources.
2. Human Resources reviews the information and submits it to the Job Classification Committee.
3. Job Classification Committee reviews the request and forwards their recommendation to the Boone County Commission for a decision.

| **Current Position Title**<br>**Director of Planning and Building Inspection** | **Present Pay Range**<br>60 | **Proposed Pay Range** |
|---|---|---|
| **Department**<br>**New-Resource Management** | **Position Number(s)**<br>63-1710 | **___X___Full Time**<br>**_____Part Time** |

**Reason(s) for requested pay range** (Attach additional sheets if necessary.) Plans, organizes and directs the functions of the planning, code enforcement and building inspection; hires, trains and develops staff; establishes annual operating budgets; serves as Managing Consultant to the BCRSD. **This position will take on the responsibility of coordinating and overseeing the Design and Construction division of Public Works to ensure interaction and cooperation with the planning and building inspection staff. As planning, design and construction are an integral parts of transportation planning, this will allow the county to take a more active approach to updating our CATSO plan. This restructuring will allow for a more streamlined approach to reviewing, permitting and inspecting new developments within the county; and allow for the complete integration of all county development regulations to achieve consistency.**

Directs the development and implementation of comprehensive land use plans; coordinates and provides guidance to landowners, the general public, the Planning & Zoning Commission and the Board of Adjustment; negotiates with developers, engineers, surveyors and attorneys regarding type and amount of infrastructure requirements for project approval and conditions of development approval.

Directs the monitoring developments throughout construction and implementation phases to ensure compliance with County regulations and conditions of approval established by the Planning & Zoning Commission and the County Commission.

Directs building inspection and code enforcement functions; ensures that all aspects of the national building code and County regulations for residential and commercial building are enforced. **The director will be responsible for cross-training the code inspectors with the road construction inspectors to implement the new stormwater and stream buffer ordinances.** .

## In This Classification:

What is the number of present vacancies: 0_ What is the total number of positions: 11.75 + **15 D&C**
In the last 12 months, how many employees have separated due to:

*Resignation:* 0 *Dismissal:* 0 *Transfer:* 0 *Promotion:* 0

## Recruitment Efforts

Describe recent recruitment efforts for this position: **N/A**

## Equity

What effect, if any, will this proposal have on salary relationships with other positions in your office and/or positions in other offices?

**There are no other department heads that have this wide ranging responsibility. Not only will this position be responsible for the existing duties, but oversight of 15 more employees within the Design and Construction side of Public Works. And some oversight of engineering responsibilities as needed to help the Facility Maintenance Manager.**

## Implementation

If approved, what is the plan for implementation? (Attach additional sheets if necessary.)

**The implementation of combining these two departments will take place once the build out of the Government Center's third floor is completed. The director is already working with the interim-director of Public works to review policy and develop a plan for a smooth transition.**

Provide salary data showing competitive pay rate information and its source. (Attach additional sheets if necessary.) **We believe this new position to be equivalent to the Public Works Director position as far as responsibility and management oversight. The proposed organizational chart includes three separate divisions under the Director, Planning Services, Inspection Services and Engineering Services. In reviewing other like job positions, we believe a Range 67 is appropriate.**

***Attach the Position Description Questionnaire for this position giving details of assigned duties.***

Administrative Authority's Signature

Date

523-2009

# CERTIFIED COPY OF ORDER

**STATE OF MISSOURI** } **ea.**
**County of Boone**

November Session of the October Adjourned **Term. 20** 09

**In the County Commission of said county, on the** 5th **day of** November **20** 09

**the following, among other proceedings, were had, viz:**

Now on this day the County Commission of the County of Boone does hereby approve the following budget revision to purchase a skid mounted deck seal spray applicator for Public Works:

| Department | Account | Department Name | Account Name | Decrease $ | Increase $ |
|---|---|---|---|---|---|
| 2040 | 92300 | Public Works- Main | Rpl Mach & Equip | 2,450.00 | |
| 2040 | 91300 | Public Works- Main | Machinery & Equip | | 2450.00 |

Done this 5th day of November, 2009.

Kenneth M. Pearson
Presiding Commissioner

Karen M. Miller
District I Commissioner

Skip Elkin
District II Commissioner

ATTEST:

Wendy S. Noren
Wendy S. Noren
Clerk of the County Commission

524 -2009

# CERTIFIED COPY OF ORDER

**STATE OF MISSOURI** } **ea.**
**County of Boone**

November Session of the October Adjourned **Term. 20** 09

**In the County Commission of said county, on the** 5th **day of** November **20** 09

**the following, among other proceedings, were had, viz:**

Now on this day the County Commission of the County of Boone does hereby approve the Sheriff's Department request to reclassify position # 346 from Receptionist at pay range 18, to Office Specialist at pay range 20.

Done this 5th day of November, 2009.

Kenneth M. Pearson
Presiding Commissioner

Karen M. Miller
District I Commissioner

Skip Elkin
District II Commissioner

ATTEST:
Wendy S. Noren KS
Wendy S. Noren
Clerk of the County Commission

**Reclassify Position #346 Receptionist to an Office Specialist**
**Prepared October 27, 2009**
* Position would be budgeted at the mid-point of the range

**Current**

| Pos # | Title | Range | Min | Mid | Max | 2009 Budget Rate | | % of Mid-pt | Budgeted Hours | Salary/Wages Budget | FICA Budget | Workers' Comp Budget | Disability Insurance Budget | Total FY 2009 Budget |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 346 | Receptionist | 18 | 9.77 | 12.21 | 14.65 | 13.04 | | 107% | 2080 | $ 27,123 | $ 2,075 | $ 92 | $ 100 | $ 29,390 |
| new # | Office Specialist | 20 | 10.26 | 12.83 | 15.40 | 12.83 | * | 100% | 2080 | $ 26,686 | $ 2,042 | $ 91 | $ 98 | $ 28,917 |
| | | | | | | | | | Budgetary Impact | $ (437) | $ (33) | $ (1) | $ (2) | $ (473) |

(A new Office Specialist would be paid at the rate of 11.54 for the remainder of 2009 so the savings would be even greater than $473)

**Current 2010 Budget**

| Pos # | Title | Range | Min | Mid | Max | 2010 Budget Rate | | % of Mid-pt | Budgeted Hours | Salary/Wages Budget | FICA Budget | Workers' Comp Budget | Disability Insurance Budget | Total FY 2010 Budget |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 346 | Receptionist | 18 | 9.77 | 12.21 | 14.65 | 13.04 | | 107% | 2080 | $ 27,123 | $ 2,075 | $ 92 | $ 100 | $ 29,390 |
| new # | Office Specialist | 20 | 10.26 | 12.83 | 15.40 | 12.83 | * | 100% | 2080 | $ 26,686 | $ 2,042 | $ 91 | $ 98 | $ 28,917 |
| | | | | | | | | | Budgetary Impact | $ (437) | $ (33) | $ (1) | $ (2) | $ (473) |

**Mid-point of Ranges**

| Pos # | Title | Range | Min | Mid | Max | Budget Rate | | % of Mid-pt | Budgeted Hours | Salary/Wages Budget | FICA Budget | Workers' Comp Budget | Disability Insurance Budget | Total FY 2009 Budget |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 346 | Receptionist | 18 | 9.77 | 12.21 | 14.65 | 12.21 | | 100% | 2080 | $ 25,397 | $ 1,943 | $ 86 | $ 94 | $ 27,520 |
| new # | Office Specialist | 20 | 10.26 | 12.83 | 15.40 | 12.83 | * | 100% | 2080 | $ 26,686 | $ 2,042 | $ 91 | $ 98 | $ 28,917 |
| | | | | | | | | | Budgetary Impact | $ 1,290 | $ 99 | $ 4 | $ 4 | $ 1,397 |