§ 1. WRITTEN WARNING FORM.

DeWITT COUNTY BOARD

Courthouse • Clinton, IL 61727

WRITTEN WARNING

TO: ______________________________ DATE: ______________________

You are hereby notified that you are being issued a written warning for violation of ______________________
____.

On the ________ day of __________ , ________ , you did ________________________________
____
____
____.

You are also hereby notified that a copy of this written warning will be placed in your personnel file. Any future violation(s) of any guidelines, policies, procedures, rules or regulations will result in further disciplinary action.

DO NOT REPEAT THIS ACTION.

____
Department Head/Elected Official

I, ______________________________ , hereby acknowledge the receipt of this written warning.

____
Signature/date

Ref. 10.1.2
(11-06-90)

§ 2. ORDER OF SUSPENSION FORM.

DeWITT COUNTY BOARD

Courthouse • Clinton, IL 61727

ORDER OF SUSPENSION

TO: ____

You are hereby notified that you are suspended from duty, as a ________________ for the County of DeWitt, DeWitt County ________(Department)__________ , for a period of ____________ hours/days.

The suspension shall be effective on ____ .

The suspension shall be for the following reason(s): ______________________________
____
____
____ .

This suspension shall be ______________ pay.

This order of suspension was served on you this __________ day of _____________ , ______ , at _____ AM/PM.

____
Department Head/Elected Official

I, __________________________ , hereby acknowledge receipt of the foregoing order of suspension, and recognize that the order of suspension is with/without pay.

____
Employee

Ref. 10.1.3
(11-06-90)

§ 3. PHYSICAL EXAMINATION RECORD.

PHYSICAL EXAMINATION RECORD

____________ (Last Name – PRINT) ____________ (First Name) ______ (Initial)

____________ (Social Security Number) ____/____/____ (Date of Birth MM/DD/YY)

____________ (Street Address)

____________ (Town/City) ____________ (State) ______ (Zip)

(____) ____-____ (Daytime Phone) (____) ____-____ (Home Phone)

1.	Have you ever been diagnosed or treated for	**Please Check**	
a.	Asthma/emphysema/pleurisy	☐ Yes	☐ No
b.	Allergies	☐ Yes	☐ No
c.	Diabetes	☐ Yes	☐ No
d.	Liver Disease (ex: Hepatitis/Cirrhosis)	☐ Yes	☐ No
e.	Kidney Disease	☐ Yes	☐ No
f.	Heart Disease (ex: Heart Attack/Angina/Chest Tightness)	☐ Yes	☐ No
g.	High Blood Pressure	☐ Yes	☐ No
h.	Seizure (Convulsions)	☐ Yes	☐ No
i.	Psychological Illness (ex: Depression/Anxiety)	☐ Yes	☐ No
j.	Low Back Pain	☐ Yes	☐ No
k.	Tuberculosis	☐ Yes	☐ No
l.	Cancer	☐ Yes	☐ No
m.	Color Blindness	☐ Yes	☐ No
n.	Vision less than 20/40, not corrected, either eye	☐ Yes	☐ No
o.	Any other significant illnesses, diseases or injuries	☐ Yes	☐ No

Please explain any **YES** answers: ____________

2.	Have you ever been hospitalized before?	☐ Yes	☐ No
	Have you ever had any surgeries?	☐ Yes	☐ No

List type and date of surgery and reason for hospitalization ____________

3.	In the **PAST**, have you had:		
a.	Recurrent skin itching, redness, hives	☐ Yes	☐ No
b.	Frequent shortness of breath	☐ Yes	☐ No
d.	Frequent or recurring cough	☐ Yes	☐ No
e.	Sneezing	☐ Yes	☐ No
e.	Loss of consciousness (passed out	☐ Yes	☐ No
f.	Trouble concentrating or memory problems	☐ Yes	☐ No

		Please Check	
g.	Back injury or pain	☐ Yes	☐ No
h.	Shoulder injury or pain	☐ Yes	☐ No
i.	Knee injury or pain	☐ Yes	☐ No
j.	Arm or leg injuries or pain	☐ Yes	☐ No
k.	Neck injuries or pain	☐ Yes	☐ No
l.	Any tingling or numbness of the hands and feet	☐ Yes	☐ No

Please explain any **YES** answers:______________________________

____

4. Are you taking any medications? ☐ Yes ☐ No
   If **YES**, list medications including prescription and over-the-counter medications:______________________________

   ____

5. Do you currently use tobacco products? ☐ Yes ☐ No
   a. Type: ☐ cigarettes ☐ pipe ☐ cigars
   b. Amount per day________
   c. Number of years________

6. Have you ever used tobacco products? ☐ Yes ☐ No
   a. Year stopped____________

7. Do you drink alcohol? ☐ Yes ☐ No
   If **YES**, average number of drinks per day________

8. Have you ever worked around or with:

a.	Lead	☐ Yes	☐ No
b.	Arsenic	☐ Yes	☐ No
c.	Sulfur Oxides	☐ Yes	☐ No
d.	Silica	☐ Yes	☐ No
e.	Organic Solvents	☐ Yes	☐ No
f.	Insecticides/Pesticides	☐ Yes	☐ No
g.	Toxic Chemical	☐ Yes	☐ No
h.	Radiation	☐ Yes	☐ No
i.	Noisy areas	☐ Yes	☐ No

If **YES** to any of the above, have you ever had an injury/illness as a result of the exposure: Explain:______

____

____

9. Have you ever had a **work-related** injury/illness that caused you to miss more than one (1) day of work? ☐ Yes ☐ No
   If **YES**, explain:______________________________

   ____

10. Have you ever had work restrictions (temporary and/or permanent? ☐ Yes ☐ No
    If **YES**, explain:______________________________

    ____

- 3 -

		Please Check	
11.	Do you have a disability which requires a reasonable accommodation:	☐ Yes	☐ No

If YES, explain:______________________________

____

12. Do you have any condition that would prevent you from:

a.	Pushing/pulling/lifting/carrying greater than 50 pounds	☐ Yes	☐ No
b.	Climbing ladders/stairs/poles/scaffolding/ramps	☐ Yes	☐ No
c.	Working at heights	☐ Yes	☐ No
d.	Working on uneven/slippery/moving/hilly surfaces	☐ Yes	☐ No
e.	Bending/stooping/kneeling/twisting/crouching/crawling cramped positions	☐ Yes	☐ No
f.	Handling or grasping with the left or right hand	☐ Yes	☐ No
g.	Performing repetitive motions of the hand/wrist/arm/leg	☐ Yes	☐ No
h.	Using tools that vibrate or have cutting edges	☐ Yes	☐ No
i.	Using your arms or legs in full range of motion activities	☐ Yes	☐ No
j.	Standing/walking/sitting	☐ Yes	☐ No
k.	Stand/walk/sit for extended periods of time	☐ Yes	☐ No
l.	Differentiating colors/depth perception	☐ Yes	☐ No
m.	Working a rotation 1st/2nd/3rd shift	☐ Yes	☐ No
n.	Working greater than 8 hours/day or 40 hours/week	☐ Yes	☐ No
o.	Driving a motor vehicle	☐ Yes	☐ No
p.	Working around electrical current/steam/moving parts	☐ Yes	☐ No
q.	Working in temperature below 32 or above 90 degrees	☐ Yes	☐ No
r.	Wearing a dust mask or respirator	☐ Yes	☐ No
s.	Working in areas with fumes/dusts/mists/gases dampness	☐ Yes	☐ No
t.	Working alone or working with the public	☐ Yes	☐ No
u.	Shoveling	☐ Yes	☐ No
v.	An irregular meal schedule	☐ Yes	☐ No
w.	Performing any other work related tasks	☐ Yes	☐ No

Please explain any **YES** answers:______________________________

____

13. **FOR WOMEN ONLY**

Are you pregnant? ☐ Yes ☐ No

I certify that the above information, supplied by me, is true to the best of my knowledge and I understand, if necessary, Dr. John Warner Hospital/Rural Health Clinic may contact me for further follow-up.

______________________________ ______________________________
Signature Date

Physical Exam Record
Form #277
08/09/10 - Revised

§ 4. PRE-EMPLOYMENT PHYSICAL EXAMINATION RECORD.

PRE-EMPLOYMENT PHYSICAL EXAMINATION RECORD

TO BE FILLED IN BY MEDICAL EXAMINER

Name____

Height________ Weight________ Time________ Blood Pressure________ Pulse________

Respiration__________ Temp__________

Aided

Vision: Distant – R20__________ L20__________ Distant – R20__________ L20__________

Color Vision______________________________

Visual performance as measured by Titmus Vision Tester meets the desirable level for specific job.

Yes ☐ No ☐

NORMAL	CLINICAL EVALUATIONS	ABNORMAL	COMMENTS
	General Appearance		
	Head, Mouth Neck		
	Ears, Nose, Throat, Thyroid		
	Eyes		
	Lungs and Chest (include breasts)		
	Heart (Rhythm, Sounds)		
	Vascular System (Varicosities, etc.)		
	Abdomen		
	Hernia/Ing. Rings		
	Upper Extremities (Range of Motion)		
	Lower Extremities (Range of Motion)		
	Musculoskeletal System		
	Skin		
	Neurologic		
	Lymphatics		

(Describe Abnormal findings in Comments section)

Comments:____

____

____

____

____

Physician's Signature ______________________ Date ______________

RHC-Pre-Employment Physical Exam. Record
Form #278
08/09/10 - Revised

§ 5. RECEIPT FOR FMLA FORMS.

I, ________________________________ , hereby acknowledge receipt of the FMLA forms. The forms included are the mandatory employee notice, employee FMLA leave request and the FMLA medical certification. I understand that the forms must be completed in full by myself and my medical provider, and must be submitted in a timely manner.

____
(Employee Signature) (Date)

____
(Supervisor or Designee Signature) (Date)

§ 6. FMLA MANDATORY EMPLOYEE NOTICE.

Mandatory Employee Notice

Employee Rights and Responsibilities under the Family and Medical Leave Act

Basic Leave Entitlement

FMLA requires covered employers to provide up to 12 weeks of unpaid, job-protected leave to eligible employees for the following reasons:

- For incapacity due to pregnancy, prenatal medical care or child birth
- To care for the employee's child after birth, or placement for adoption or foster care
- To care for the employee's spouse, son or daughter, or parent, who has a serious health condition
- For a serious health condition that makes the employee unable to perform the employee's job

Military Family Leave Entitlements

Eligible employees with a spouse, son, daughter, or parent on active duty or call to active duty status in the National Guard or Reserves in support of a contingency operation may use their 12-week leave entitlement to address certain qualifying exigencies. 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.

FMLA also includes a special leave entitlement that permits eligible employees to take up to 26 weeks of leave to care for a covered service member during a single 12-month period. A covered service member is a current member of the Armed Forces, including a member of the National Guard or Reserves, on active duty, who has a serious injury or illness incurred in the line of duty that may render the service member medically unfit to perform his or her duties for which the service member is undergoing medical treatment, recuperation, or therapy; or is in outpatient status; or is on the temporary disability retired list.

Benefits and Protections

During FMLA leave, the employer must maintain the employee's health coverage under any "group health plan" on the same terms as if the employee had continued to work. Upon return from FMLA leave, most employees must be restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms.

Use of FMLA leave cannot result in the loss of any employment benefit that accrued prior to the start of an employee's leave.

Eligibility Requirements

Employees are eligible if they have worked for a covered employer for at least one year, for 1,250 hours over the previous 12 months, and if at least 50 employees are employed by the employer within 75 miles.

Definition of Serious Health Condition

A serious health condition is an illness, injury, impairment, or physical or mental condition that involves either an overnight stay in a medical care facility, or continuing treatment by a health care provider for a condition that either prevents the employee from performing his or her job functions, or prevents the qualified family member from participating in school or other daily activities.

Subject to certain conditions, the continuing treatment requirement may be met by:

- A period of incapacity of more than three consecutive calendar days combined with at least two visits to a health care provider
- One visit and a regimen of continuing treatment
- Incapacity due to pregnancy, or incapacity due to a chronic condition

Other conditions may meet the definition of continuing treatment.

(Continued)

(Continued)

Use of Leave

An employee does not need to use this leave entitlement in one block. Leave can be taken intermittently or on a reduced leave schedule when medically necessary. Employees must make reasonable efforts to schedule leave for planned medical treatment so as not to unduly disrupt the employer's operations. Leave due to qualifying exigencies may also be taken on an intermittent basis.

Substitution of Paid Leave for Unpaid Leave

Employees may choose or employers may require use of accrued paid leave while taking FMLA leave. In order to use paid leave for FMLA leave, employees must comply with the employer's normal paid leave policies.

Employee Responsibilities

Employees must provide 30 days advance notice of the need to take FMLA leave when the need is foreseeable. When 30 days notice is not possible, the employee must provide notice as soon as practicable and generally must comply with an employer's normal call-in procedures.

Employees must provide sufficient information for the employer to determine if the leave may qualify for FMLA protection and the anticipated timing and duration of the leave. Sufficient information may include that the employee is unable to perform job functions, the family member is unable to perform daily activities, the need for hospitalization or continuing treatment by a health care provider, or circumstances supporting the need for military family leave. Employees also must inform the employer if the requested leave is for a reason for which FMLA leave was previously taken or certified. Employees may also be required to provide a certification and periodic recertification supporting the need for leave.

Employer Responsibilities

Covered employers must inform employees requesting leave whether they are eligible under FMLA. If they are, the notice must specify any additional information required as well as the employees' rights and responsibilities. If they are not eligible, the employer must provide a reason for the ineligibility.

Covered employers must inform employees if leave will be designated as FMLA-protected and the amount of leave counted against the employee's leave entitlement. If the employer determines that the leave is not FMLA-protected, the employer must notify the employee.

Unlawful Acts by Employers

FMLA makes it unlawful for any employer to:

- Interfere with, restrain, or deny the exercise of any right provided under FMLA
- Discharge or discriminate against any person for opposing any practice made unlawful by FMLA or for involvement in any proceeding under or relating to FMLA

Enforcement

An employee may file a complaint with the U.S. Department of Labor or may bring a private lawsuit against an employer.

FMLA does not affect any federal or state law prohibiting discrimination, or supersede any state or local law or collective bargaining agreement which provides greater family or medical leave rights.

For additional information: 1-866-4US-WAGE (1-866-487-9243), TTY: 1-877-889-5627, or **www.wagehour.dol.gov**

FMLA section 109 (29 U.S.C. § 2619) requires FMLA covered employers to post the text of this notice. Regulations 29 C.F.R. § 825.300(a) may require additional disclosures.

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§ 7. EMPLOYEE FMLA LEAVE REQUEST.

Employee FMLA Leave Request
(Family/Medical Leave Request Form)

Eligible employees are entitled under the Family and Medical Leave Act (FMLA) to take up to 12 or 26 weeks of job-protected leave for certain family and medical reasons. Submit this request form to your human resources manager at least 30 days before the leave is to begin, when possible. When 30 days' advance submission of the request form is not possible, submit the request as soon as possible. Our Company reserves the right to deny or postpone leave if you do not give adequate notice when permitted under federal and/or state law.

Employee Information

Please print.

Name: ____________________ Employee ID # ____________________

Department: ____________________ Job Title: ____________________

Today's Date: ___/___/___ Hire Date: ___/___/___ Supervisor: ____________________

Status: ☐ Full-Time ☐ Part-Time ☐ Temporary

Reason for Requesting Leave

I am requesting family/medical leave for the following reasons: (check all that apply)

☐ Birth of my child; to care for my newborn child

☐ Placement of a child with me for ________ adoption ________ foster care

☐ Leave to care for a family member with a serious health condition

Relationship of family member to you: ____________________

☐ My own serious health condition

☐ Qualifying exigency because a family member is on active duty or has been called to active duty in the Armed Forces.

Relationship of family member to you: ____________________

☐ Leave to care for a family member who is a member of the Armed Forces and who is undergoing medical treatment or recuperating from a serious injury or illness incurred while on active duty

Relationship of family member to you: ____________________

☐ Other (please explain) ____________________

____

Duration of Leave

Leave expected to begin ___/___/___ Leave expected to end ___/___/___

If intermittent or reduced-leave schedule is being requested, please explain why it is needed and the proposed leave schedule:

____

____

Employee Certification and Signature

I certify that the above information is true and correct to the best of my knowledge:

Employee signature: ____________________ Date: ___/___/___

EMPLOYER: This form should be treated as a medical record and must be maintained separately from employee personnel files, in locked cabinets with only designated personnel having access. As an employer, you should retain this original and provide a photocopy of the form to your employee along with the Company Response form within a reasonable period of time.

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§ 8. FMLA MEDICAL CERTIFICATION (EMPLOYEE).

FMLA Medical Certification (Employee)

(Certification of Healthcare Provider for Employee's Serious Health Condition)

SECTION I: For Completion by the EMPLOYER

INSTRUCTIONS: The Family and Medical Leave Act (FMLA) provides that you, as an employer, may require an employee seeking FMLA protections and leave due to a serious health condition to submit a medical certification issued by the his or her healthcare provider. Please complete Section I before giving this certification to your employee. While you are not required to use this certification, you may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. §§825.306-825.30. In accordance with federal law, employers generally must maintain records and documents relating to medical certifications, recertifications or medical histories of employees, created for FMLA purposes, as confidential medical records and in separate files/records from the usual personnel files.

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: Please complete Section II before giving this certification 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 under regulation 29 U.S.C. §§2613, 2614(c)(3). Not providing a complete and sufficient medical certification may result in a denial of your FMLA request under regulation 20 C.F.R. §825.313. Your employer must give you at least 15 calendar days to return this form under regulation 29 C.F.R. §825.305(b).

Your name: ______________________________
First Middle Last

SECTION III: For Completion by the HEALTHCARE PROVIDER

INSTRUCTIONS: Your patient has requested leave under the FMLA. Answer, fully and completely, all applicable parts. Several questions pertain 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. The last page provides space for additional information, if necessary. 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 began: ___/___/___

   Probable duration of condition: ______________________________

   ____

   Was the patient admitted for an overnight stay in a hospital, hospice or residential medical care facility? ☐ Yes ☐ No

   If **yes**, 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? ☐ Yes ☐ No

   Was medication, other than over-the-counter medication, prescribed? ☐ Yes ☐ No

   Was the patient referred to other healthcare provider(s) for evaluation or treatment (e.g., physical therapist)? ☐ Yes ☐ No

   If **yes**, state the nature of such treatments and expected duration of treatment: ______________________________

   ____

   ____

   ____

2. Is the medical condition pregnancy? ☐ Yes ☐ No

   If **yes**, expected delivery date: ___/___/___

3. (Use the information provided by the employer in Section I to answer this question. If the employer doesn't 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 or her job functions.)

   Is the employee unable to perform any of his or her job functions due to the condition? ☐ Yes ☐ No

   If **yes,** 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 or her medical condition, including any time for treatment and recovery? ☐ Yes ☐ No

   If **yes**, 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? ☐ Yes ☐ No

   If **yes**, are the treatments or the reduced number of hours of work medically necessary? ☐ Yes ☐ No

   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:

   __________ hours a day: __________ days a week from __________________ through __________________

7. Will the condition cause episodic flare-ups periodically preventing the employee from performing his or her job functions? ☐ Yes ☐ No

   Is it medically necessary for the employee to be absent from work during the flare-ups? ☐ Yes ☐ No

   If **yes**, 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 six months (e.g., one episode every three months lasting one-two days):

   Frequency: __________ times a __________ week(s) __________ month(s)

   Duration: __________ hours or __________ day(s) per episode

Additional Information

(Identify question number with your additional answer.)

Signature of Healthcare Provider: ______________________ Date: ___/___/___

PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT

If submitted, it is mandatory for employers to retain a copy of this disclosure in their records for three years, in accordance with 29 U.S.C. §2616; 29 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 (1215-0181). The Department of Labor estimates that it will take an average of 20 minutes for respondents to complete this collection of information, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, U.S. Department of Labor, Room S-3502, 200 Constitution AV, NW, Washington, DC 20210. **DO NOT SEND THE COMPLETED FORM TO THE WAGE AND HOUR DIVISION; RETURN IT TO THE PATIENT.**

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§ 9. FMLA MEDICAL CERTIFICATION (FAMILY MEMBER).

FMLA Medical Certification (Family Member)
(Certification of Healthcare Provider for Family Member's Serious Health Condition)

SECTION I: For Completion by the EMPLOYER

INSTRUCTIONS: The Family and Medical Leave Act (FMLA) provides that you, as an employer, may require an employee seeking FMLA protections and leave to care for a covered family member with a serious health condition to submit a medical certification issued by the healthcare provider of the covered family member. Please complete Section I of this certification before giving it to your employee. While you are not required to use this certification, you may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. §§825.306-825.30. In accordance with federal law, employers generally must maintain records and documents relating to medical certifications, recertifications or medical histories of employees' family members, created for FMLA purposes, as confidential medical records and in separate files/ records from the usual personnel files.

Employer name and contact: ____________________

____

____

SECTION II: For Completion by the Employee

INSTRUCTIONS: Please complete Section II before giving this certification to your family member's 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, under regulation 29 U.S.C. §§2613, 2614(c)(3). Not providing a complete and sufficient medical certification may result in denial of your FMLA request, under regulation 29 C.F.R. §825.313. Your employer must give you at least 15 calendar days to return this form under regulation 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: ___/___/___

SECTION III: For Completion by the HEALTHCARE PROVIDER

INSTRUCTIONS: The employee listed on the previous page has requested leave under the FMLA to care for your patient. Answer, fully and completely, all applicable parts below. Several questions pertain 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. The last page provides space for additional information, if necessary. Please be sure to sign the form on the last page.

Provider' name and business address: ____________________

____

Type of practice/medical specialty: ____________________

Telephone: ( ) ____________ Fax: ( ) ____________

PART A: Medical Facts

1. Approximate date condition began: ___/___/___

   Probable duration of condition: ____________________

   ____

   Was the patient admitted for an overnight stay in a hospital, hospice or residential medical care facility? ☐ Yes ☐ No

   If **yes**, dates of admission: ____________________

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

   Will the patient need to have treatment visits at least twice a year due to the condition? ☐ Yes ☐ No

   Was medication, other than over-the-counter medication, prescribed? ☐ Yes ☐ No

   Was the patient referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)? ☐ Yes ☐ No

   If **yes**, state the nature of such treatments and expected duration of treatment: ____________________

   ____

   ____

   ____

   ____

   ____

2. Is the medical condition pregnancy? ☐ Yes ☐ No

   If **yes**, expected delivery date: ___/___/___

3. Describe other relevant medical facts, if any, related to the patient's 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 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? ☐ Yes ☐ No

   Estimate the beginning and ending dates for the period of incapacity: ____/____/____ (Beginning) ____/____/____ (Ending)

   During this time, will the patient need care? ☐ Yes ☐ No

   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? ☐ Yes ☐ No

   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 it is medically necessary:

   ____

   ____

   ____

6. Will the patient require care on an intermittent or reduced schedule basis, including any time for recovery? ☐ Yes ☐ No

   Estimate the hours the patient needs care on an intermittent basis, if any:

   ________ hours a day: ________ days a week from ____________ through ____________

   Explain the care needed by the patient, and why it is medically necessary:

   ____

   ____

   ____

   ____

7. Will the condition cause episodic flare-ups periodically preventing the patient from participating in normal daily activities?

   ☐ Yes ☐ No

   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 six months (e.g., one episode every three months lasting one-two days):

   Frequency: ________ times a ________ week(s) ________ month(s)

   Duration: ________ hours or ________ day(s) per episode

   Does the patient need care during the flare-ups? ☐ Yes ☐ No

   Explain the care needed by the patient, and why it is medically necessary: ____________________

   ____

   ____

   ____

Additional Information

(Identify question number with your additional answer.)

Signature of Healthcare Provider: ____________________ Date: ___/___/___

PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT

If submitted, it is mandatory for employers to retain a copy of this disclosure in their records for three years, in accordance with 29 U.S.C. § 2616; 29 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 (1215-0181). The Department of Labor estimates that it will take an average of 20 minutes for respondents to complete this collection of information, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, U.S. Department of Labor, Room S-3502, 200 Constitution AV, NW, Washington, DC 20210. DO NOT SEND THE COMPLETED FORM TO THE WAGE AND HOUR DIVISION; RETURN IT TO THE PATIENT.

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§ 10. COMPANY RESPONSE (ELIGIBILITY).

Company Response (Eligibility)
(Notice of Eligibility and Rights and Responsibilities)

Note to Employer and Employee:
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 where at least 50 employees are employed by the company within 75 miles. Use of this form by employers is optional, but a fully completed form provides employees the information required by 29 C.F.R. § 825.300(b), which must be provided within five business days of the employee's notifying the employer of the need for FMLA leave. Part B provides employees the 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

Date: ____/____/____

To: ______________________ (Employee) From: ______________________ (Employer Representative)

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 or 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 service member with a serious injury or illness.
- ☐ Other ______________________.

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 toward this requirement.
  - ☐ You have not met the FMLA's 1,250-hours-worked requirement during the 12-month period.
  - ☐ You do not work and/or report to a site where 50 or more employees are employed by the company 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, for us to determine whether your absence qualifies as FMLA leave, you must return the following information to us by** ______________________.

- ☐ 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

(If a certification is requested, as your employer, we 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.

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If your leave does qualify as FMLA leave, you will have the following **responsibilities** while on FMLA leave (only checked boxes 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 canceled, 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 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 after 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 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 you indicated, you will be required to notify us at least two workdays before 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 service member 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 after FMLA leave for a reason other than: 1) the continuation, recurrence, or onset of a serious health condition that would entitle you to FMLA leave; 2) the continuation, recurrence, or onset of a covered service member's serious injury or illness that 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 five business days, whether your leave will be designated as FMLA leave and count toward 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 (1215-0181). 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.**

§ 11. COMPANY RESPONSE (DESIGNATION).

Company Response (Designation)
(Designation Notice)

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. 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. Use of this form by employers is optional, but a fully completed one provides an easy method to supply to employees the written information required by 29 C.F.R. §§ 825.300(c), 825.301, and 825.305(c).

To: ______________________________ (Employee) Date: ____/____/____

We have reviewed your request for leave under the FMLA and any supporting documentation 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, 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 whether 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 ______________________ (Provide at least seven calendar days.), unless it is not practicable under the particular circumstances despite your diligent good-faith efforts, or your leave may be denied.

____
(Specify information needed to make the certification complete and sufficient.)

☐ We are exercising our right to have you obtain a second or third opinion medical certification at our expense, and we will provide further details at a later time.

☐ **Your FMLA Leave request is Not Approved.**
☐ **The FMLA does not apply to your leave request.**
☐ **You have exhausted your FMLA leave entitlement in the applicable 12-month period.**

PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT
It is mandatory for employers to inform employees in writing whether leave requested under the FMLA has been determined to be covered under the FMLA. 29 U.S.C. § 2617; 29 C.F.R. §§ 825.300(d), (e). It is mandatory for employers to retain a copy of this disclosure in their records for three years. 29 U.S.C. § 2616; 29 C.F.R. § 825.500. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number (1215-0181). 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.
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§ 12. EMPLOYEE ACKNOWLEDGMENT FORM REGARDING COMMUNICATIONS SYSTEMS.

I, ______________________________ , acknowledge having received a copy of the DeWitt County policy and procedures regarding communications systems.

I understand that I maintain responsibility for adhering to these policies and for the security and safety of the "password" issued to me in order to access the communications system. Any infraction of these policies shall subject me to discipline appropriate under the circumstances.

Furthermore, I recognize that it is my responsibility to report to the County Board administrative offices any problems that I may experience in accessing systems and/or any suspected violations of the policies insuring systems use and safety.

DATE: ____

SIGNATURE: ____

Printed: ____

(To be kept by the Employee)

I, ______________________________ , acknowledge having received a copy of the DeWitt County policy and procedures regarding communications systems.

I understand that I maintain responsibility for adhering to these policies and for the security and safety of the "password" issued to me in order to access the communications system. Any infraction of these policies shall subject me to discipline appropriate under the circumstances.

Furthermore, I recognize that it is my responsibility to report to the County Board administrative offices any problems that I may experience in accessing systems and/or any suspected violations of the policies insuring systems use and safety.

DATE: ____

SIGNATURE: ____

Printed: ____

(To be kept by the Employer)

§ 13. EMPLOYEE ACKNOWLEDGMENT FORM REGARDING PHOTOGRAPHIC IDENTIFICATION CARDS.

I, ________________________________ , acknowledge having received a copy of the policy regarding photographic identification cards.

I understand that I maintain responsibility for adhering to this policy. Any infraction of this policy shall subject me to discipline appropriate under the circumstances.

Furthermore, I recognize that it is my responsibility to report to the Executive Administrative Assistant to the County Board or the Chief Deputy of the DeWitt County Sheriff's Department any lost or stolen card.

DATE: ____

SIGNATURE: ____

Printed: ____

(To be kept by the Employee)

I, ________________________________ , acknowledge having received a copy of the policy regarding photographic identification cards.

I understand that I maintain responsibility for adhering to this policy. Any infraction of this policy shall subject me to discipline appropriate under the circumstances.

Furthermore, I recognize that it is my responsibility to report to the Executive Administrative Assistant to the County Board or the Chief Deputy of the DeWitt County Sheriff's Department any lost or stolen card.

DATE: ____

SIGNATURE: ____

Printed: ____

(To be kept by Employer)

§ 14. DISCLAIMER.

It is the intent of this handbook to provide employees with the county's personnel policies. Employees are encouraged to familiarize themselves with the contents of this handbook concerning employment with the county.

The personnel handbook is not to be construed as an employment contract and is not intended to create contractual obligations of any kind. Neither the employee nor the county is bound to continue the employment relationship if either chooses, at its will, to end the relationship at any time.

I have received this personnel policy handbook.

____________________________ ____

Date Employee

(Ord. passed 11-28-2011)