APPENDIX C:

EMPLOYEE FORMS
(SEE THE FOLLOWING PAGES)

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

U.S. Department of Labor
Wage and Hour Division

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

OMB Control Number: 1235-0003
Expires: 7/31/2018

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

Employer name and contact: _____

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

Employee's essential job functions: _____

_____

Check if job description is attached: ____

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

Your name: _____
First Middle Last

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

Provider's name and business address: _____

Type of practice / Medical specialty: _____

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

PART A: MEDICAL FACTS

1. Approximate date condition commenced: _____

   Probable duration of condition: _____

   Mark below as applicable:
   Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility?
   ___No ___Yes. If so, dates of admission:

   _____

   Date(s) you treated the patient for condition:

   _____

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

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

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

   _____

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

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

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

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

   _____

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

   _____

   _____

   _____

   _____

   _____

   _____

   _____

CONTINUED ON NEXT PAGE

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.**

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

U.S. Department of Labor
Wage and Hour Division

OMB Control Number: 1235-0003
Expires: 7/31/2018

In general, to be eligible an employee must have worked for an employer for at least 12 months, meet the hours of service requirement in the 12 months preceding the leave, and work at a site with at least 50 employees within 75 miles. While use of this form by employers is optional, a fully completed Form WH-381 provides employees with the information required by 29 C.F.R. § 825.300(b), which must be provided within five business days of the employee notifying the employer of the need for FMLA leave. Part B provides employees with information regarding their rights and responsibilities for taking FMLA leave, as required by 29 C.F.R. § 825.300(b), (c).

[Part A – NOTICE OF ELIGIBILITY]

TO: _____
Employee

FROM: _____
Employer Representative

DATE: _____

On _____, you informed us that you needed leave beginning on _____ for:

_____ The birth of a child, or placement of a child with you for adoption or foster care;

_____ Your own serious health condition;

_____ Because you are needed to care for your ____ spouse; _____child; _____ parent due to his/her serious health condition.

_____ Because of a qualifying exigency arising out of the fact that your ____ spouse; _____son or daughter; _____ parent is on covered active duty or call to covered active duty status with the Armed Forces.

_____ Because you are the ____ spouse; _____son or daughter; _____ parent; _____ next of kin of a covered servicemember with a serious injury or illness.

This Notice is to inform you that you:

_____ Are eligible for FMLA leave (See Part B below for Rights and Responsibilities)

_____ Are **not** eligible for FMLA leave, because (only one reason need be checked, although you may not be eligible for other reasons):

- _____ You have not met the FMLA's 12-month length of service requirement. As of the first date of requested leave, you will have worked approximately ___ months towards this requirement.
- _____ You have not met the FMLA's hours of service requirement.
- _____ You do not work and/or report to a site with 50 or more employees within 75-miles.

If you have any questions, contact _____ or view the FMLA poster located in _____.

[PART B-RIGHTS AND RESPONSIBILITIES FOR TAKING FMLA LEAVE]

As explained in Part A, you meet the eligibility requirements for taking FMLA leave and still have FMLA leave available in the applicable 12-month period. **However, in order for us to determine whether your absence qualifies as FMLA leave, you must return the following information to us by** _____. (If a certification is requested, employers must allow at least 15 calendar days from receipt of this notice; additional time may be required in some circumstances.) If sufficient information is not provided in a timely manner, your leave may be denied.

____ **Sufficient certification to support your request for FMLA leave. A certification form that sets forth the information necessary to support your request ____is/____ is not enclosed.**

____ **Sufficient documentation to establish the required relationship between you and your family member.**

____ **Other information needed (such as documentation for military family leave):** _____

_____

_____

____ **No additional information requested**

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 this form, you will be required to notify us at least two workdays prior to the date you intend to report for work.

If your leave does qualify as FMLA leave you will have the following rights while on FMLA leave:

- You have a right under the FMLA for up to 12 weeks of unpaid leave in a 12-month period calculated as:
  - _____ the calendar year (January – December).
  - _____ a fixed leave year based on _____.
  - _____ the 12-month period measured forward from the date of your first FMLA leave usage.
  - _____ a "rolling" 12-month period measured backward from the date of any FMLA leave usage.
- You have a right under the FMLA for up to 26 weeks of unpaid leave in a single 12-month period to care for a covered servicemember with a serious injury or illness. This single 12-month period commenced on _____.
- Your health benefits must be maintained during any period of unpaid leave under the same conditions as if you continued to work.
- You must be reinstated to the same or an equivalent job with the same pay, benefits, and terms and conditions of employment on your return from FMLA-protected leave. (If your leave extends beyond the end of your FMLA entitlement, you do not have return rights under FMLA.)
- If you do not return to work following FMLA leave for a reason other than: 1) the continuation, recurrence, or onset of a serious health condition which would entitle you to FMLA leave; 2) the continuation, recurrence, or onset of a covered servicemember's serious injury or illness which would entitle you to FMLA leave; or 3) other circumstances beyond your control, you may be required to reimburse us for our share of health insurance premiums paid on your behalf during your FMLA leave.
- If we have not informed you above that you must use accrued paid leave while taking your unpaid FMLA leave entitlement, you have the right to have ____ **sick,** ____**vacation,** and/or ___ **other leave** run concurrently with your unpaid leave entitlement, provided you meet any applicable requirements of the leave policy. Applicable conditions related to the substitution of paid leave are referenced or set forth below. If you do not meet the requirements for taking paid leave, you remain entitled to take unpaid FMLA leave.

  ____For a copy of conditions applicable to sick/vacation/other leave usage please refer to _____ available at: _____

  ____Applicable conditions for use of paid leave: _____

  _____

  _____

  _____

  _____

Once we obtain the information from you as specified above, we will inform you, within 5 business days, whether your leave will be designated as FMLA leave and count towards your FMLA leave entitlement. If you have any questions, please do not hesitate to contact:

_____ at _____

PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT

It is mandatory for employers to provide employees with notice of their eligibility for FMLA protection and their rights and responsibilities. 29 U.S.C. § 2617; 29 C.F.R. § 825.300(b), (c). It is mandatory for employers to retain a copy of this disclosure in their records for three years. 29 U.S.C. § 2616; 29 C.F.R. § 825.500. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. The Department of Labor estimates that it will take an average of 10 minutes for respondents to complete this collection of information, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, U.S. Department of Labor, Room S-3502, 200 Constitution Ave., NW, Washington, DC 20210. **DO NOT SEND THE COMPLETED FORM TO THE WAGE AND HOUR DIVISION.**

Designation Notice (Family and Medical Leave Act)

U.S. Department of Labor
Wage and Hour Division

U.S. Wage and Hour Division

OMB Control Number: 1235-0003
Expires: 7/31/2018

Leave covered under the Family and Medical Leave Act (FMLA) must be designated as FMLA-protected and the employer must inform the employee of the amount of leave that will be counted against the employee's FMLA leave entitlement. In order to determine whether leave is covered under the FMLA, the employer may request that the leave be supported by a certification. If the certification is incomplete or insufficient, the employer must state in writing what additional information is necessary to make the certification complete and sufficient. While use of this form by employers is optional, a fully completed Form 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.**

VILLAGE OF BEDFORD PARK

Travel Reimbursement Request

6701 S Archer Rd, Bedford Park, IL 60501 Phone: (708) 458-2067 Fax (708) 458-2079 www.villageofbedfordpark.com

Employee _____ **Dept.** _____

TRAVEL PERIOD

From: _____ **Thru:** _____

TRAVEL EXPENSE
(Receipts attached)

Date	Expense Type (Meals, Lodging, Airfare, etc.)	Amount
	Travel Expense Total	

AUTOMOBILE MILEAGE

Vehicle	Beginning Mileage	Ending Mileage	Miles Driven	Mileage Allowance	Amount
				Mileage Total	

Grand Total _____

Signature _____ **Date** _____

110618

VILLAGE OF BEDFORD PARK

Tuition Reimbursement

6701 S Archer Rd, Bedford Park, IL 60501 Phone: (708) 458-2067 Fax (708) 458-2079 www.villageofbedfordpark.com

1. **Preapproval through Motion.** A request to attend courses that will later be reimbursable must be requested through a motion of a board meeting. The request will include the course names, start dates and supervisor approval. Complete the section below and submit to supervisor to be included in board meeting.

Name _____ Date _____

Department _____ College Attending _____

Course 1 _____ Course 2 _____

Course 3 _____ Course 4 _____

Start Date _____ Year _____

Program _____

☐ Schedule is attached

Dept. Approval _____

2. **Course Completion.** Course grades AND proof of payment must be submitted for the payout after the course is completed. Actual payment receipt is required (credit card receipt or register receipt from college). If paid with school loans, the receipt must show payment on loan.

☐ Grade report is attached

☐ Proof of payment is attached

☐ Copy of approved motion

Date submitted for payment _____

Please submit to Dyane or Rhonda in Village Hall.

Injury Reporting Guidelines

In order for **on-the-job-injuries** to be processed properly, this form must be completed as soon as possible by each Village Department and promptly forwarded to the Village Hall. Please follow these guidelines:

1. Complete the report **in-full**. An "N/A" (*for not applicable*) may be filled in any box that does not apply.
2. After completing the report, print it out and sign/date it as the "**Supervisor Preparing the Report**".
3. Have the injured **Employee** review the report and sign/date it.
4. The Supervisor will then forward the completed and signed report to the **Department Head** of the respective department.
5. The **Department Head** will review the report, provide any comments, sign/date it, and forward it to the Village Hall immediately.

If there is any anticipated or expected delay in getting this report forwarded to the Village Hall in a prompt manner, (*waiting for employee signature, department head not available, etc*.), please consider emailing the form to involved parties to expedite the process and please consider providing an unfinished report to the Village Hall so the processing of the injury can begin.

Post Injury Expectations

Employees are our greatest asset and we want you to be well. If you are injured at work, please be aware of the process.

1. If you are hurt, get assistance with administering first aid if it is needed.
2. If you need to see the company physician, go to Proven during work hours (M-F, 7a – 5p).
3. If you need medical treatment, you will need your worker's compensation claim number. You can get this from Dyane or Yvette in the village administrative office (708-458-2067). You can also ask the provider to obtain the claim number from Dyane at dyane@villageofbedfordpark.com. Please note the injury report is needed before a claim can be filed with work comp.
4. Proven Occupational Health is connected to MidAmerica Orthopedics and can refer you to their best orthopedic physician for your injury if further treatment or x-rays are needed. You can usually be treated and/or have testing done within a reasonable wait time.
5. There is no medical cost to you for work-related injuries so do not provide your personal insurance information.
6. A physician needs to provide an order to excuse you from work.
7. Worker's compensation benefits will be determined if more than three work days are missed.
8. If you need medical attention and/or miss work, you will be contacted by a work comp representative. You can expect to be interviewed by the rep regarding details of the incident. All requested information needs to be provided to this person.
9. If you are off due to a work comp injury, you will be expected to call in to your department every Friday morning before noon to provide an update of your status. This is in addition to providing a work status report to your department and the administrative office (Dyane) following every physician appointment.
10. If therapy is recommended by your physician and approved by work comp, you will need to provide a therapy schedule.
11. If off on work comp, light duty is available and may return you to work sooner. You will receive full pay on light duty.
12. When returning to light duty and full duty you will need a work release from your treating physician and Proven Occupation Health. Please contact your department or the administrative office to set up the return to work visit with Proven.

VILLAGE OF BEDFORD PARK

On the Job Injury Report

6701 S Archer Rd, Bedford Park, IL 60501 Phone: (708) 458-2067 Fax (708) 458-2079 www.villageofbedfordpark.com

This report is to be completed in full by the employee's immediate supervisor and promptly forwarded to the Department head.

Employee Name:	**Job Title:**	**Department:**
Employee Home Address:	**City:**	**State/Zip:**
Employee Phone Number (Cell):	**Employee Phone Number (Home):**	**Employee Phone Number (Work/Other):**
Employee Email Address:	**Employee Date of Birth:**	**Employee SS#:**
Date of Injury:	**Time of Injury:**	**Time Employee Started Work:**
Location of Injury (Address):	**City:**	**State/Zip:**

Specific Job Operation When Accident Occurred:

Detailed Description of Injury: ***(Include nature of injury (or illness), how it occurred, part(s) of the body affected, or any other relevant information):***

Fire Incident #:	**Police Incident #:**	**Type of Training (if applicable):**

Were department policies followed? If not, please explain:

EMS Attention Offered (yes/no):	**EMS Attention Refused (yes/no):**	**EMS Attention Administered By (*list EMS agency*):**

Additional Medical Attention Administered By (*list Hospital, Immediate Care, Occupational Health, etc.*):

Address:	**City:**	**State/Zip:**

Doctor Name:	**Additional Medical Remarks:**

****If the injury was serious enough to require medical attention, complete a detailed narrative below, including any witness statements. Include a copy of an Ambulance report if applicable. Forward all relevant reports to a supervisor as soon as possible.**

Detailed Narrative of Medical Attention:

Was there any lost time from the job (yes/no): ☐ YES ☐ NO	**If so, how many hours:**

Witness Name:	**Phone Number:**	**Email Address:**
Witness Name:	**Phone Number:**	**Email Address:**
Witness Name:	**Phone Number:**	**Email Address:**

Supervisor (preparing report):	**Rank / Title:**
Supervisor Signature:	**Date:**

Employee Name:	**Rank / Title:**
Employee Signature:	**Date:**

Department Head (receiving report):	**Rank / Title:**
Department Head Signature:	**Date:**

Department Head Remarks:

Original Copy to: **Village Hall**