APPENDIX A FORMS

Additional copies of the forms in this appendix are available at the Department of Support Services Personnel Division and/or online at the Shasta County Personnel internet (www.co.shasta.ca.us) and intranet (http://intranet/shasta-county) websites.

REQUEST FOR CONSIDERATION OF WORK PLACE ACCOMMODATION

Under law, a person has a disability if he/she has a physical or mental impairment that limits a major life activity. A qualified employee with a disability is an employee who is qualified to perform the essential functions of a position with or without reasonable accommodation. Essential functions are primary job duties that are intrinsic to a position.

Instructions: If a qualified employee with a disability wishes to request an accommodation, he/she must complete this form and submit it to the department head. If the individual is unable to complete the form, due to a disability, he/she may request that another party complete it on his/her behalf. The form also requires medical substantiation of disability and information regarding the extent of work task limitations. Review County policy for complete directions and/or employee appeal process.

EMPLOYEE NAME / WORK PHONE # _____

CLASS & DEPARTMENT _____

EMPLOYEE'S ADDRESS _____

_____

EMPLOYEE'S HOME PHONE # _____

TO BE COMPLETED BY EMPLOYEE:

Describe the Work Place Accommodation that you are requesting and why (attach an additional sheet of paper if you need more space). Attach your physician's statement describing specific work limitations (example: Employee has a permanent lifting restriction: cannot lift more than 20 lbs from floor to waist, and no more than 10 lbs above the waist or overhead). A request that does not provide sufficient information regarding employee's work limitations will not be processed.

_____

_____

_____

_____

_____

TO BE COMPLETED BY DEPARTMENT HEAD, OR HIS/HER DESIGNEE:

Recommendation (If financial impact is less than $3,000, describe the accommodation provided.)

_____

_____

_____

_____

Employee Signature/Date Department Head, or his/her designee, Signature/Date

cc: Employee and ADA Coordinator (When form is completed)

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JURY DUTY/MILITARY LEAVE ABSENCE

1. Employee's Name _____

2. Employee's Department _____

3. Type of Leave: ☐ Local Jury Duty ☐ Federal Jury Duty ☐ Military Leave

4. Period of Absence _____

In order to substantiate my need for paid time off to perform jury duty or military service, attached is a copy of my Jury summons or military orders and my time card indicative "JUR" for jury duty or "MIL" for military leave for the appropriate dates.

I am also aware that all jury duty fees must either be waived or turned over to the county to partially offset the cost of the salary and benefits paid to me while I am on jury duty.

_____

Signature of Employee Date

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Confidential--Personnel Records

OUTSIDE EMPLOYMENT/CORPORATE AFFILIATION STATEMENT
NOTICE TO SHASTA COUNTY

Name_____
Home Address_____
Telephone: home_____ work_____
Shasta County Dept. of Employment_____ Position_____
Immediate Supervisor_____
Department Head, or his/her designee, _____

Proposed Outside Employment

Employer_____
Employer address _____
Employer telephone_____
If self-employment, describe _____
_____
_____
Nature of services or product to be provided _____
_____
_____
Job description (please attach if the employer has a written job description)_____
_____
Expected hours of employment_____
Duration of employment_____

The relationship, if any, of the outside employment to County approvals or reviews_____
_____
_____
Other relevant information _____
_____

Proposed Corporate Affiliation

Name and address of corporation: _____
_____
Does employee procure, draft, negotiate, or monitor contracts for the department? Describe:
_____
_____
Position with corporation: _____
Describe any compensation from corporation (salary, stipend or reimbursements)? _____
_____
_____
Describe any current or likely contracts between corporation and employee's department:
_____
_____
_____

I certify that I have read the Shasta County Incompatible Outside Employment Policy and I will comply with all of the rules of such policy in pursuing outside employment.

I certify that the foregoing is true and correct.

Dated:_____ Employee_____

Department Head or his /her designee
Review: _____ Date: _____
Signature

FOR OFFICE USE: **(Confidential--File in Personnel Records Only)**

Date received:_____ Notes:_____ Initialed____

ORDER TO CEASE OUTSIDE EMPLOYMENT/CORPORATE AFFILIATION

I,_____, Department Head, or his/her designee, hereby order you,_____ _____, employee in the department under my authority, to cease working at the outside employment or to cease your corporate affiliation, described as follows:_____

_____

_____

_____

_____

_____

This order is being issued because that activity is incompatible, inconsistent, or in conflict with your employment with Shasta County for the following reasons:_____

_____

_____

_____

_____

_____

_____

The following are additional conditions attached to this order relating to your outside employment or corporate affiliation, including terms and conditions relating to suspending such outside employment pending the final determination of this matter:_____

_____

_____

_____

_____

_____

You have 10 business days from the receipt of this order to appeal this order in writing to the Outside Employment/Corporate Affiliation Review Committee or Grievance Board in care of the Personnel Director, or his/her designee. A Notice of Appeal form has been attached to this order for your use. You may be required to submit additional information regarding your outside employment.

Signature_____ Date _____

Title _____

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EMPLOYEE APPEAL FORM ORDER TO CEASE OUTSIDE EMPLOYMENT/CORPORATE AFFILIATION -

I,_____, hereby appeal my Department Head's, or his/her designee, order to cease my outside employment or corporate affiliation described as follows:_____

_____

_____

I appeal this order on the basis that my outside employment or corporate affiliation is not incompatible, inconsistent or in conflict with my employment with Shasta County as determined by the Shasta County Incompatible Outside Employment/Corporate Affiliation Policy for the following reasons:_____

_____

_____

_____

_____

_____

_____

I certify that the foregoing is true and correct.

DATED_____ Signature_____

Print name/Title_____

When complete, submit to the Personnel Director, or his/her designee.

Date received:_____ Initialed: _____

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COUNTY OF SHASTA
RECIPIENT APPLICATION
ACCRUED VACATION DONATION PROGRAM

I hereby make application to access the Accrued Vacation Donation Bank. I understand that in order to qualify as a recipient, I must meet program criteria, submit appropriate medical justification, and receive the approval of the Vacation Donation Review Committee.

I understand the requirement in Personnel Rules Chapter 29, Section 29.3, D #8 which states: Recipients are required to combine payment from the vacation bank with other forms of payment from State Disability Insurance, Workers' Compensation, or any other source in such a manner not to exceed the employee's gross salary.

I have or willhave exhausted all of my accrued vacation, appropriate sick leave, CTO or administrativeleave, andholiday credits and ameligible for leave without pay beginning_____(Date).

I believe my circumstances qualify as verifiable long-term illness or injury of self or immediate family member, and are described as follows (even though you have attached medical justification, you **must** complete the following section in your own words.):

_____

_____

_____

_____

(Attach additional sheets if necessary)

I **have received, read and understand the current Accrued Vacation Donation Policy (dated February 5, 2008)** and, in the event I am determined to be eligible as a recipient, I agree to abide by the terms of that Policy. I understand that becoming an eligible recipient does not guarantee that donated vacation time in the Bank will be sufficient to meet my needs. If I am determined to be ineligible, I understand the decision of the Vacation Donation Review Committee is final and therefore not subject to any form of appeal.

By signing this form I **understand that** I **am signing a medical release authorizing the Vacation Donation Review Committee to have access to pertinent personal medical information.** I **understand** I **will be responsible, as requested by the Committee, to provide the required documentation regarding my or my family member's illness or injury.** I **also understand that the committee will keep that information confidential and will use it only for the purposes of determining benefits under this policy.**

Please submit a separate request for leave of absence to the Department Head, or his/her designee. The Leave of Absence must be approved by your Department Head, or his/her designee, before the Vacation Donation Bank Committee can consider your request. You should provide only necessary work-related medical information when you request the Leave of Absence.

_____	_____
Name of Employee (Type/Print)	Signature of Employee
_____	_____
Title	Vacation Donation ReviewCommittee
_____	_____
Department	Action Date

Date_____

NOTE: Attach medical and other relevant documentation verifying and/or clarifying your or your family's disabling illness or injury.

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COUNTY OF SHASTA

VACATION DONATION PROGRAM
REQUEST FOR ASSIGNMENT OF ACCRUED VACATION TIME

I hereby request that_____hours of vacation time now accrued to me be assigned and credited to:_____
(Employee's Name or General Bank)

I understand that this request must be approved by my appointing authority, and that if this request is granted, the amount of my accrued vacation time will be reduced accordingly.

I hereby represent that the above request is freely made by me and that I will not be compensated for this assignment by any person or entity, including but not limited to the County of Shasta or any employee using donated hours. I hereby release the County of Shasta and all its officers, agents, and employees from any liability to me for the reduction in my accrued vacation time that will result if this request is granted.

I further understand that if this request is granted, the use by the recipient employee of the amount of vacation time donated pursuant to this request will be limited to the period of time the recipient employee remains on leave status. If the recipient employee returns to paid County employment status or terminates his/her County employment, any amount of my accrued vacation time assigned to him/her pursuant to this request that is not used by him/her prior to his/her return to paid County employment status or termination of County employment will be placed in the general bank for use by other eligible County employees.

_____ _____
Name (Please Print) County ID Number

_____
Signature of Employee

I concur with this request:

_____ _____
Signature of Department Head, or his/her designee Date

To Payroll Office:_____
(Date) Dept. No.

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POSITION CLASSIFICATION QUESTIONNAIRE

Shasta County
Personnel Unit
Department of Support Services

Return Original Copy to Personnel

TO EMPLOYEE:

This is a job inventory. The information requested by this questionnaire will be used to evaluate your duties and responsibilities in determining the appropriate classification of your position. You are being asked to complete the form because you are the best person to provide complete information about your job. Please do not request that your position be studied if you are solely concerned about its salary range or other factors that are listed below as outside the scope of this program. You are most welcome to request a study if there have been significant changes in your duties and responsibilities.

This study is not concerned with how well you perform on the job, whether your workload is appropriate, whether your particular function or organization is properly staffed, or whether the salary of the position is appropriate. This questionnaire seeks to gather data of two types: Task data -- information regarding the specific work functions performed by you; and Behavioral data -- information regarding the knowledge, skills, and abilities necessary to adequately perform the duties of your job. This is the method used by the County to see that positions are fairly and consistently classified.

Please write your responses on one copy of the questionnaire as completely and accurately as possible, then give it to your supervisor for review and signature. Your supervisor will give it to your department head for review and signature. It will then be returned to you for signature. You sign it last. Return it to your supervisor who will forward it to the Personnel Office. Be sure to keep a copy for your files.

BACKGROUND INFORMATION

Your name_____ Payroll Title_____

Working Title (if different)_____

Department_____ Division_____

Work Phone Number_____

Address where you report to work_____

Length of time in current position_____ Hours of work_____ to _____

Name, title and work phone of immediate supervisor_____

1. Has your positions been studied for reclassification in the past? If so, when, and describe what has changed since the last study.

_____

_____

_____

_____

2. Briefly describe what you believe to be the main purpose of your job.

_____

_____

_____

_____

3. Education (circle number of years you have completed):

Elementary/Secondary: 1 2 3 4 5 6 7 8 9 10 11 12
Graduated: Yes No GED

College/University: 1 2 3 4 5 6 + Major

Graduated: Yes No Degree

4. What license, registration or certificate (if any) is required by the County for performance of your job?_____

_____

5. List any machines or equipment you use (including motor vehicles), and check the frequency.

	Monthly	Weekly	Daily	All the time

6. If you type regularly, what typing speed is necessary for your position? WPM

7. If you take shorthand, what shorthand speed is necessary for your position? WPM

8. SPECIFIC DUTIES AND RESPONSIBILITIES

This is the most important part of the questionnaire. Describe in detail the regular duties you perform. Begin with the most important duty and list all duties in order of importance, not in order of time spent on each. Fill in the approximate percentage of total time spent performing each duty. The percentage of total time reported must equal 100%, regardless of the number of hours worked. Use additional sheets if necessary.

PERCENT OF TIME	DUTIES PERFORMED
PERCENT	DUTIES PERFORMED

OF TIME	

9. How much and what type of education do you feel is necessary to perform your job?

_____

_____

10. How much work experience similar in nature do you feel is necessary to qualify for your job?

_____

_____

11. How long do you feel it would take for someone to become familiar with your job and perform it satisfactorily?

_____

_____

12. List the specific knowledge and skills you believe someone must have to successfully perform your job. Please be specific, e.g., knowledge of rules or regulations (by type), knowledge of the

activities of your department or work unit, equipment operation skills, supervisory skills, communication skills, etc.

13. List those organizations, if any, with whom you come in contact. List both internal as well as external contacts, and why they are necessary in the course of work.

Organization	Reason for Contact	Frequency of Contact

14. What is the consequence if you make an error in the course of your duties?

15. Describe the most difficult and/or major decisions you make in the course of your duties.

16. Describe the nature of the direction or supervision you receive, and by whom.

17. List those employees under your direct supervision. If none, state so.

Name Payroll Title

18. Describe the nature of your supervisory responsibilities, if applicable. Please be specific, e.g., hiring, discipline, work planning, evaluations, training, etc.

19. Is there a classification that you feel is more appropriate considering your duties?

20. PHYSICAL DEMANDS - This section is principally included in order to update job specifications in accordance with ADA requirements.

A. How much on-the-job time is spent in the following physical activities? Show the amount of time by checking the appropriate boxes below.

	None	Up to 1/3 of time	1/3 to 2/3 of time	More than 2/3 of time
Stand				
Walk				
Sit				
Use hands to finger, handle or feel				
Reach with hands and arms				
Climb or balance				
Stoop, kneel, crouch, or crawl				
Talk or hear				
Taste or smell				

B. Does this job require that weight be lifted or force be exerted? If so, how much and how often? Check the appropriate box below.

	None	Up to 1/3 of time	1/3 to 2/3 of time	More than 2/3 of time
Up to 10 lbs				
Up to 25 lbs				
Up to 50 lbs				
Up to 100 lbs				
More than 100 lbs				

C. Does this job have any special vision requirements? Check all that apply.

[ ] Close Vision (clear vision at 20 inches or less)

[ ] Distance Vision (clear vision at 20 feet or more)

[ ] Color Vision (ability to identify and distinguish colors)

[ ] Peripheral Vision (ability to observe an area that can be seen up and down or to the left and right while eyes are fixed on a given point)

[ ] Depth Perception (three-dimensional vision, ability to judge distances and spatial relationships)

[ ] Ability to Adjust Focus (ability to adjust the eye to bring an object into sharp focus)

[ ] No Special Vision Requirements

D. Please list any additional comments on specific physical demands required for this position.

_____

_____

_____

21. WORK ENVIRONMENT

A. How much noise is typical for the work environment of this job? Check the appropriate level below.

[ ] Very Quiet (Examples: forest trail, isolation booth for hearing test)

[ ] Quiet (Examples: library, private office)

[ ] Moderate Noise (Examples: office w/typewriters or computer printers, light traffic)

[ ] Loud Noise (Examples: metal can manufacturing, large earth moving equipment)

[ ] Very Loud Noise (Examples: jackhammer work, front row at rock concert)

B. How much exposure to the following environmental conditions does this job require? Show the amount of time by checking the appropriate boxes below.

	None	Up to 1/3 of time	1/3 to 2/3 of time	More than 2/3 of time
Wet, humid conditions (non-weather)				
Work near moving mechanical parts				
Work in high, precarious places				
Fumes or airborne particles				
Toxic or caustic chemicals				
Outdoor weather conditions				
Extreme cold (non-weather)				
Extreme heat (non-weather)				
Risk of electrical shock				
Work with explosives				
Risk of radiation				
Vibration				

C. Please list any additional comments on the specific working conditions encountered while performing the duties of this position.

_____

_____

_____

_____

_____

_____

22. Please provide a summary statement as to why you think it is appropriate for your position to be reclassified including any significant changes in your duties and responsibilities that have occurred over the past year.

This completes the questionnaire. Please submit as stated in the earlier instructions. Thank you for your cooperation and assistance.

PLEASE SIGN IN ORDER INDICATED:

1. CERTIFICATE OF IMMEDIATE SUPERVISOR

Does the completed questionnaire accurately reflect the incumbent's duties, responsibilities and other factors relative to the job? Yes No (If no, see comments below)

Are there any special courses or specialized knowledge needed for the position that were not covered in the questionnaire? If so, what are they?

What is the most responsible/complex aspect of this job?

Comments (use additional sheets if necessary)

_____

_____

_____

_____

Supervisor's Signature_____Date_____

Supervisor's Name (Print)_____Phone No._____

---

2. CERTIFICATE OF DEPARTMENT HEAD, OR HIS/HER DESIGNEE (It is not required that Department Head, his/her designee, complete this section. However, he/she is encouraged to take advantage of this opportunity to provide relevant information)

I do/ do not concur with the responses of the employee and the

supervisor. Comments (use additional sheets if necessary)

_____

_____

_____

Department Head's, or his/her designee, Signature_____Date_____

Department Head's, or his/her designee, Name (Print)_____Phone No._____

---

3. CERTIFICATE OF EMPLOYEE

I certify that the responses are my own and to the best of my knowledge are complete and accurate.

Date:_____Employee's Signature_____

09/13/01

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POSITION CLASSIFICATION

APPEAL FORM

Shasta County
Personnel Unit
Original

Return Original Copy
to Personnel

TO EMPLOYEE

This form is to be submitted only if you desire to formally appeal the recent recommendation made on how your position should be classified. In order to be considered, it must include as much factual information as possible. Use additional sheets if needed.

I agree with the class being recommended for my position. Yes_____No _____

I agree with the content of the class specification being recommended for my positions.

Yes_____No _____

I disagree because _____

_____

_____

Name_____Current Payroll Title _____

Department_____Division _____

Date_____Employee's Signature _____

IMMEDIATE SUPERVISOR

I do do not concur with the responses of the employee.

Comments (use additional sheets if needed) _____

_____

_____

Date:_____ Supervisor Signature: _____

DEPARTMENT HEAD, OR HIS/HER DESIGNEE

I do___do not_____concur with the responses of the employee and the supervisor.

Comments (use additional sheets if needed) _____

_____

_____

_____

Date _____

Department Head's or his /her designee Signature _____

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Employee Recognition Award

Nomination

NOMINATION PROCEDURE:

All employees and registered volunteers with a minimum of one year of service are eligible for Employee Recognition Awards. To qualify, an employee must demonstrate exemplary performance and meet the seven eligibility criteria outlined in the Employee Recognition Award Program Policy. These criteria are *customer service, professionalism, ethical standards, initiative/innovation, teamwork, productivity and role model for other public employees* (See Chapter 36 of the Personnel Rules.)
Any employee who meets these criteria may be nominated for an award. All nominations must be made by another county employee and be submitted on this ballot form to the employee's department head.

NOMINEE'S NAME: _____

DEPARTMENT: _____

DIVISION: _____

JOB TITLE: _____

NOMINATED BY: _____

REASONS FOR NOMINATION:

Please attach a narrative description of the reasons for the nomination. Please be as specific as possible. The Employee Recognition Committee considers the following criteria: *customer service, professionalism, ethical standards, initiative/innovation, teamwork, productivity and role model for other public employees* (See Chapter 36 of the Personnel Rules). Note any activities, work projects, incidents or projects that will support your comments and illustrate the criteria listed above. If necessary use additional sheets of paper, but confine your narrative to three pages including this page.

_____

Preparer's Signature Date

DEPARTMENT HEAD'S RECOMMENDATIONS AND COMMENTS

_____

Department Head, or his/her designee, Signature Date

SCREENING OF PERSONNEL FILE BY PERSONNEL DIRECTOR, OR HIS/HER DESIGNEE:
(review for sustained disciplinary actions, letters of reprimand or "below expected standards" evaluations for the past five years):
Eligible _____ Ineligible _____

Note: All nominations must be signed by the department head and submitted to the Personnel Director by the third Friday of each month to be considered for an award the following month.

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SHASTA COUNTY FLEXIBLE WORK HOURS PLAN

The Flex Plan is an alternative work schedule that is voluntary and intended as a valuable benefit to employees. The plan is also a benefit to the department because it will result in improved production by allowing employees flex time for personal business without having to use leave balances.

The plan is voluntary for employees and may be modified or discontinued by management at any time.

FLEX SCHEDULE POLICY

The flex schedule program is a privilege to be used to accumulate hours for time off during the same 40-hour work period. General County policy requires its personnel to work a full scheduled week, although short workweeks (Labor Day, Thanksgiving, etc.) may be accommodated appropriately.
The Flex Schedule Supervisory Control Requirements:

1. Flextime will be approved by the supervisor on Monday morning for the current week and will be maintained online for all to view.
2. The supervisor must approve any changes requested within the work week.
3. There must be adequate personnel available in each work unit during office hours.

How Flex Schedule Works:

1. Employees must work 40 hours a week.
2. Flextime optional hours will be from 7:00 a.m. to 6:00 p.m. with ½ hour option for lunch.
3. No more than 9 hours can be worked per day unless approved by management.
4. Sick leave cannot exceed 8 hours in one day.
5. Employees cannot take less than a one-half hour lunch.
6. There will be no carry-over from one week to another.
7. Rest breaks will not be adjusted for flextime accumulation.
8. Rest breaks cannot be taken in conjunction with flextime.
9. Employees may not be at work earlier than 15 minutes prior to scheduled start time and leave no later than 15 minutes after scheduled quit time.
10. Flex time worked or taken must be in ½ hour increments.
11. Employees may flex from ½ hour up to a maximum of 8 hours per workweek.
12. Employee's time card must reflect the actual hours worked and must account for 40 hours each week.
13. Upon approval from the supervisor on Monday morning, employees may opt in or out for any week.

<u>Flextime Examples:</u>

No. 1 (Friday afternoon off)

Monday - 7:30 am - 12:30 pm, lunch ½ hour
1:00 pm - 5:00 pm = 9 hours
Tuesday - 7:30 am - 12:30 pm, lunch ½ hour
1:00 pm - 5:00 pm = 9 hours
Wednesday - 7:30 am - 12:30 pm, lunch ½ hour
1:00 pm - 5:00 pm = 9 hours

Thursday - 7:30 am - 12:30 pm, lunch ½ hour
1:00 pm - 5:00 pm = 9 hours
Friday - 7:30 am - 11:30 pm =4 hours
Total Hours = 40

No. 2 (Monday morning off)

Same as No. 1, except that Monday is a 4-hour day, beginning at 1:00 pm and Tuesday through Friday are 9- hour days.

No. 3 (Off every day at 4:00 pm)

Monday - Friday - 7:30 am - 12:30 pm, lunch ½ hour
1:00 pm - 4:00 pm = 40 hours

No. 4 (Start every day at 9:00 am)

Monday - Friday - 9:00 am - 1:00 pm, lunch ½ hour
1:30 pm - 5:30 pm = 40 hours

No. 5 (Variable Flex)

Monday - Friday - 7:30 am - 5:00 pm, lunch ½ hour
5 hours off during mid-day taken in one hour increments
Total hours = 40

Various versions of these examples can be developed to accommodate the needs of the employee and the department.

Employees are expected to be at their workstation and ready to work at the time specified each workday. Once at work, employees are expected to remain diligently at work throughout the day, except during lunch and break periods. If an employee is late, the flex schedule should be adjusted accordingly.

REQUEST FOR FLEX SCHEDULE

Flex Schedule Policy

The flex schedule program is a privilege to be used to accumulate hours for time off during the same 40-hour work period. General County policy requires employees to work a full scheduled week, although short workweeks (Labor Day, Thanksgiving, etc.) may be accommodated appropriately.

Flex Schedule Requirements

1. Flextime must be approved by your supervisor on Monday a.m. or prior for that current week's flex schedule.
2. There must be adequate personnel available to cover workloads during office hours.
3. You must still work 40 hours in a week.
4. Sick leave cannot exceed 8 hours in one day.
5. You cannot take less than ½ hour for lunch.
6. There will be no carry-over from one week to another.
7. Rest breaks will not be adjusted for flextime accumulation.
8. Rest breaks cannot be taken in conjunction with flextime.
9. Flextime worked or taken must be in ½ hour increments.
10. Your time card must reflect the actual hours worked and must account for 40 hours each week.

_____
Employee Name

_____
Proposed Flex Schedule dates and times

_____
Reason for Flex Schedule Request

_____ _____
Employee Signature Date

_____ _____
Supervisor Signature Date

_____ _____
Department Head, or his/her designee, Signature Date

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Performance Evaluation Instructions

A Performance Evaluation (PE) for Shasta County employees is prepared as required by the County's Personnel Rules for all regular employees, and for extra help employees who have worked a cumulative total of 2080 hours (see Personnel Rules, Chapter 19). The PE is to be discussed with an employee privately in a face-to-face meeting. The attached, approved PE is used to **summarize and record** the employee's performance as well as discussions that are held between a supervisor and an employee for the period covered by the PE. As part of the process of continual feedback, PE ratings should never be a surprise to an employee. An employee must be given a copy of his or her PE.

PE's can be given for a variety of reasons. Annual and probationary period evaluations are the most common, but PE's can be given after lengthy or special projects, or as part of a performance improvement process. Regardless of the reason for a review, a supervisor should ensure that category ratings are applied consistently, and are related to job performance.

Ratings

A supervisor should rate an employee for each applicable criterion in a category, providing comments about specific conduct and examples of incidents which support the rating. All ratings require a narrative comment. In particular, a rating above and below "Meets Expected Standards" must be fully supported by evidence. An employee's performance must be rated within one of the following criteria:

> **Exceeds Standards:** An employee is consistently performing above what is normally expected. Since a certain high level of performance is expected of all Shasta County employees, this rating should be used sparingly to indicate exceptional performance.
>
> **Meets Expected Standards:** An employee is consistently performing well. An employee at this level is meeting the high level of performance expected of County employees. He or she is consistently meeting the agreed upon standards for his or her position.
>
> **Improvement Needed:** An employee must improve his or her performance to achieve a "Meets Expected Standards" rating. Every employee has strengths and weaknesses in different aspects of his or her job performance, and this rating can be used to indicate a weakness. If a "Needs Improvement" rating has been given, a supervisor must formulate a "Performance Improvement Plan."
>
> **Unacceptable:** An employee demonstrates substantial or serious weaknesses in his or her job performance. If a rating of "Unacceptable" has been given, a supervisor must formulate a "Performance Improvement Plan."

Weighted Categories

Each department may weigh rating categories differently. If a department places a greater weight on any rated category, the "weighted" box on the PE must be marked. A supervisor should explain to an employee, upon hire or placement in a position, the nature of any weighted job criteria that may appear on a PE. It is a supervisor's responsibility to inform all employees under his or her supervisory control or direction of expected standards upon hire or placement. If weighted categories change, a supervisor should inform every affected employee of the change as soon as possible.

Rated vs.Non-Rated Categories

Dependant upon a department's business needs, as determined by the department head, certain performance categories may not be rated. Performance categories that are rated must be marked accordingly on the PE and addressed appropriately in the category narrative. Again, it is a supervisor's

responsibility to inform all employees under his or her supervisory control or direction of rated categories upon hire or placement in a position. If rated categories change, a supervisor should inform every affected employee of the change as soon as possible.

Goals and Objectives

An Employee should be made aware of goals and objectives when first hired or placed in a position, and annually thereafter. As determined by the department head, each PE should include goals and objectives established for the employee by his or her supervisor for the next evaluation period. These goals and objectives should be selected to allow for opportunities for the employee to increase effectiveness in his or her position, as well as assist the department in achieving its mission. These goals and objectives may include (but are not limited to) lengthy or special projects, training, and ways to improve performance (if necessary), and will be evaluated annually under Category E of the PE.

Development Plan

Maintaining and improving good performance is a responsibility shared by both the employee and his or her supervisor. A PE should address an employee's development. An employee will benefit most from a development plan if the plan has several concrete ideas on how the employee can enhance his or her performance during the next evaluation period.

Performance Improvement Plan

A Performance Improvement Plan (PIP) is **mandatory** for an employee who has one or more category ratings of "Unacceptable" or "Improvement Needed." The PIP should include at least one category element for each rating below "Meets Expected Standards." To be effective, and in order to appropriately guide an employee in a deficient area of performance, a supervisor should describe, in clear terms, the performance problem, the standard of performance the supervisor expects the employee to meet, and the deadline for achieving that standard of performance. The PIP should describe all training, assistance and oversight that will be provided to an employee during the next evaluation period, and should set timelines for the employee's next performance review.

Affirmation

While a PE is being discussed with an employee in a face-to-face meeting, a supervisor should use the time to review departmental and County policies and procedures. A department may add additional review topics, however, at a minimum, the County's Policy against Discrimination and Harassment (including sexual harassment) should be discussed with an employee on an annual basis. An employee should be asked to initial a statement confirming the nature of the discussion that took place between an employee and a supervisor.

Verification

The department head or his or her designee must review a PE **before** it is discussed with an employee. An employee's signature in the "Signatures and Review" section of the PE does not indicate agreement with the PE**.** The signature is intended only to acknowledge that the content of the PE has been discussed with an employee.

SHASTA COUNTY PERFORMANCE EVALUATION

I. IDENTIFICATION

Name(Last, First, Middle Initial):	**Position Title:** ☐ **Classified** ☐ **Unclassified**("At Will")
Department Name/Division:	**Duty Assignment:**
Evaluation Period: **From:** **To:**	**Type of Evaluation:** ☐ **Annual** ☐ **Probationary Period** ☐ **Extra Help** ☐ **Other:**

II. GENERAL PERFORMANCE CATEGORIES – NARRATIVES TO BE COMPLETED FOR ALL EVALS

A. Core Competencies	*WEIGHTED	RATED	**UNACCEPTABLE** [Did not meet Expectations]	**IMPROVEMENT NEEDED** [Occasionally did not meet expectations]	**MEETS EXPECTED STANDARDS** [Meets expectations]	**EXCEEDS STANDARDS** [Strong Performance]
Level of job knowledge necessary to perform assigned job duties	☐	☐	☐	☐	☐	☐
Use of job knowledge and skills related to job duties	☐	☐	☐	☐	☐	☐
Quality and Accuracy of work performed	☐	☐	☐	☐	☐	☐
Quantity of work performed	☐	☐	☐	☐	☐	☐
Narrative:						

B. Effectiveness	*WEIGHTED	RATED	**UNACCEPTABLE**	**IMPROVEMENT NEEDED**	**MEETS EXPECTED STANDARDS**	**EXCEEDS STANDARDS**
Adapts well to work changes	☐	☐	☐	☐	☐	☐
Problem solving skills	☐	☐	☐	☐	☐	☐
Verbal communications	☐	☐	☐	☐	☐	☐
Written communications	☐	☐	☐	☐	☐	☐
Active listening skills	☐	☐	☐	☐	☐	☐
Narrative:						

C. People Skills	*WEIGHTED	RATED	**UNACCEPTABLE**	**IMPROVEMENT NEEDED**	**MEETS EXPECTED STANDARDS**	**EXCEEDS STANDARDS**
Customer service responsiveness	☐	☐	☐	☐	☐	☐
Interacting with the public	☐	☐	☐	☐	☐	☐
Working as a team member	☐	☐	☐	☐	☐	☐
Ability to resolve conflicts	☐	☐	☐	☐	☐	☐
Maintains effective, harmonious working relationships	☐	☐	☐	☐	☐	☐
Leadership skills (if applicable)	☐	☐	☐	☐	☐	☐
Narrative:						

*A check in this box identifies this factor as crucial to performance and is more heavily weighted than other factors

D. Work Place Awareness	*WEIGHTED	RATED	UNACCEPTABLE	IMPROVEMENT NEEDED	MEETS EXPECTED STANDARDS	EXCEEDS STANDARDS
Complies with County policies and procedures	☐	☐	☐	☐	☐	☐
Complies with department policies and procedures	☐	☐	☐	☐	☐	☐
Works in a safe manner	☐	☐	☐	☐	☐	☐
Obeys security protocols	☐	☐	☐	☐	☐	☐
Takes care of resources	☐	☐	☐	☐	☐	☐
Narrative:						

E. Dependability	*WEIGHTED	RATED	UNACCEPTABLE	IMPROVEMENT NEEDED	MEETS EXPECTED STANDARDS	EXCEEDS STANDARDS
Starts and leaves work as scheduled	☐	☐	☐	☐	☐	☐
Punctual for meetings or scheduled events	☐	☐	☐	☐	☐	☐
Minimizes absences so as not to impact operations	☐	☐	☐	☐	☐	☐
Meets work deadlines	☐	☐	☐	☐	☐	☐
Stays on task; avoids distractions	☐	☐	☐	☐	☐	☐
Is timely in the completion of work assignments	☐	☐	☐	☐	☐	☐
Competently completes assigned goals and objectives	☐	☐	☐	☐	☐	☐
Narrative:						

F. Management Skills [To evaluate Manager and Supervisor classifications ONLY]	*WEIGHTED	RATED	UNACCEPTABLE	IMPROVEMENT NEEDED	MEETS EXPECTED STANDARDS	EXCEEDS STANDARDS
Planning skills	☐	☐	☐	☐	☐	☐
Decision making skills	☐	☐	☐	☐	☐	☐
Ability to direct employees	☐	☐	☐	☐	☐	☐
Performance evaluations	☐	☐	☐	☐	☐	☐
Budget preparation	☐	☐	☐	☐	☐	☐
Controls costs	☐	☐	☐	☐	☐	☐
Delegation of work	☐	☐	☐	☐	☐	☐
Motivates employees	☐	☐	☐	☐	☐	☐
Career development of subordinates	☐	☐	☐	☐	☐	☐
Narrative:						

*A check in this box identifies this factor as crucial to performance and is more heavily weighted than other factors

III. OVERALL PERFORMANCE

UNACCEPTABLE	IMPROVEMENT NEEDED	MEETS EXPECTED STANDARDS	EXCEEDS STANDARDS
☐	☐	☐	☐
Overall Narrative Summary:			

IV. FUTURE PLANS/ACTIONS

☐ **GOALS AND OBJECTIVES FOR NEXT PERFORMANCE PERIOD**: With the assistance of the employee, list those goals and objectives which will increase the employee's effectiveness in his or her current position. These goals and objectives may include specific projects, tasks, or assignments that will be evaluated in Category E of this performance evaluation. Please list each goal and objective separately and include any specific completion date, if applicable, within the evaluation period. (Attach additional pages as needed.)

☐ **EMPLOYEE DEVELOPMENT PLAN:**(Optional) This section is intended to promote career development by identifying for the employee the skills or knowledge he or she should obtain in order to enhance his or her chances of promotion. (Attach additional pages asneeded.)

☐ **PERFORMANCE IMPROVEMENT PLAN:**(This is mandatory for every employee who has one or more category ratings of "Unacceptable" or "Improvement Needed.") This plan should include at least one category element for each rating below "Meets Expected Standards." The supervisor should describe the performance problem, the standard of performance the supervisor expects the employee to meet, and the deadline for achieving that standard of performance. The plan should describe all training, assistance and oversight that will be provided to the employee during the next evaluation period, and should set timelines for the employee's next review. (Attach additional pages as needed.)

V. STEP INCREASE

Approved	Denied	Not Applicable
☐	☐	☐

VI. AFFIRMATION:Departments may wish to place department-specific requirements here.

As part of the evaluation process, I reviewed and understand the County's policy against discrimination and harassment (including sexual harassment) found in the Shasta County Personnel Rules_____(Employee's initials)

VII. SIGNATURES & REVIEW

This evaluation represents my best judgment of the employee's performance:

Rater:_____ Date:

Name/Title:

I concur in and approve this evaluation:

Program Manager/Division Chief:_____ Date:

Name/Title:

I concur in and approve this evaluation:

Department Head, or his/her designee:_____ Date:

Name/Title:

I understand that my signature acknowledges the receipt of this evaluation only:

Employee:_____ Date:

Employee Name:

Comments by employee (optional):(Attach additional pages as needed)

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AUTHORIZATION & RELEASE OF INFORMATION

I have applied for a position with Shasta County. I understand that, in connection with the employment decision process, Shasta County may thoroughly investigate my background, including, but not limited to, my references, educational record, work history, certifications, criminal conviction record, records of civil actions, and other public records. I understand that these investigations will be conducted by Shasta County and/or its designated representatives to assist Shasta County in determining my qualifications for the position I am seeking. In order to assist Shasta County in obtaining documents and information to confirm my background, I hereby consent to the release of information as described below.

I authorize and direct all of my former schools and employers, and any other individual or entity that possesses information about my background to release to Shasta County, or its designated representatives, any and all information, whether or not such information is maintained in writing, that they may have concerning my educational record, work history, certifications, criminal convictions, records of civil actions, and other public records. Such information shall include but not be limited to, employment positions held, dates of employment, work achievements, performance, attendance, disciplinary history, salary record, and all of the circumstances surrounding the termination/cessation of my employment with any employer. Such information shall also include whether a former employer would re-hire me.

I direct that such information be released upon the request of any designated representative of Shasta County, regardless of any agreement, instructions, or representations I may have made to the contrary with any school, employer, or other individual or entity that possesses information about my background.

I understand and agree that I will not receive and am not entitled to know the contents of confidential reports received, and I further understand that these reports are privileged. However, I am entitled to receive copies of any records documenting an arrest, indictment, conviction, civil judicial action, tax lien, or outstanding judgment that may be provided to Shasta County, unless I waive that right by checking the box below and signing where indicated:

> I hereby waive my right to receive a copy of any record documenting an arrest, indictment, conviction, civil judicial action, tax lien, or outstanding judgment that may be provided to Shasta County.
>
> Applicant's Signature Acknowledging Waiver:
>
> _____

I release and hold harmless all schools, all past and present employers, the County of Shasta and its officers and employees, and all other individuals and entities from any and all liability or damage of whatever kind which may at any time result to me because of compliance with this authorization and release of information.

This authorization is a continuing one; if I am hired by Shasta County, it shall remain in effect during the entire period of my employment and may be used by Shasta County at any time it deems appropriate.

A copy of this form may be used in lieu of an original.

Applicant's Name: _____

Applicant's Signature: _____

Social Security Number: _____

Dated: _____

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NOTICE TO EMPLOYEES

EMPLOYEE RIGHTS AND RESPONSIBILITIES

UNDER THE CALIFORNIA FAMILY RIGHTS ACT AND/OR

PREGNANCY DISABILITY LEAVE LAW

Under the California Family Rights Act of 1993 (CFRA), if you have more than 12 months of service with us and have worked at least 1,250 hours in the 12-month period before the date you want to begin your leave, you may have a right to an unpaid family care or medical leave (CFRA leave). This leave may be up to 12 workweeks in a 12-month period for the birth, adoption, or foster care placement of your child or for your own serious health condition or that of your child, parent, spouse or registered domestic partner.

Even if you are not eligible for CFRA leave, if you are disabled by pregnancy, childbirth or related medical conditions, you are entitled to take a pregnancy disability leave (PDL) of up to four months, depending on your period(s) of actual disability. If you are CFRA-eligible, you have certain rights to take both a PDL and a CFRA leave for reason of the birth of your child. Both leaves contain a guarantee of reinstatement to the same or to a comparable position at the end of the leave, subject to any defense allowed under the law.

If possible, you must provide at least 30 days advance notice for foreseeable events (such as the expected birth of a child or a planned medical treatment for your self or of a family member). For events that are unforeseeable, we need you to notify us, at least verbally, as soon as you learn of the need for the leave.

Failure to comply with these notice rules is grounds for, and may result in, deferral of the requested leave until you comply with this notice policy.

We may require certification from your health care provider before allowing you a leave for pregnancy or your own serious health condition or certification from the health care provider of your child, parent, spouse or registered domestic partner who has a serious health condition before allowing you a leave to take care of that family member. When medically necessary, leave may be taken on an intermittent or a reduced work schedule.

If you are taking a leave for the birth, adoption or foster care placement of a child, the basic minimum duration of the leave is two weeks. However, the County will grant a request for a CFRA leave of less than two weeks duration on any two occasions. You must conclude the leave within one year of the birth or placement for adoption or foster care.

Taking a CFRA leave and/or PDL may impact certain of your benefits and your seniority date. If you want more information regarding your eligibility for a leave and/or the impact of the leave on your seniority and benefits, please contact CountyPersonnel.

If you require time off for any reason covered by PDL or CFRA, you must contact your supervisor.

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NOTICE TO EMPLOYEES

EM PLOYEE RIG HTS AND RESPONSIBILITIES UNDER THE FEDERAL 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; or
- 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 servicemember during a single 12-month period. A covered servicemember is a current member of the Armed Forces, including a member of the National Guard or Reserves, who has a serious injury or illness incurred in the line of duty on active duty that may render the servicemember medically unfit to perform his or her duties for which the servicemember 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 the functions of the employee's job, 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 3 consecutive calendar days combined with at least two visits to a health care provider or one visit and a regimen of continuing treatment, or incapacity due to pregnancy, or incapacity due to a

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 also may 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 anyproceeding 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.

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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NOTICE OF ELIGIBILITY AND RIGHTS AND RESPONSIBILITIES
FAMILY AND MEDICAL LEAVE ACT AND/OR CALIFORNIA FAMILY RIGHTS ACT

DATE: _____

TO: _____
[Employee's Name and Title]

FROM: _____
[Department Manager]

SUBJECT: Notice of Eligibility and Rights and Responsibilities — Family and Medical Leave Act and/or California Family Rights Act

PART A — Notice of Eligibility

We received information that you need 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 _____ registered domestic partner (CFRA Leave Only) _____ 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 called to active duty status in support of a contingency operation as a member of the National Guard or Reserves (FMLA Leave Only).

_____ Because you are the _____ spouse _____ son or daughter _____ parent _____ next of kin of a covered servicemember with a serious injury or illness (FMLA Leave Only).

This is to inform you that:

_____ You are eligible for Family and Medical Leave ("FMLA"). (See **Part B** below for Rights and Responsibilities).

_____ You are eligible for California Family Rights Act ("CFRA") leave. (See **Part B** below for Rights and Responsibilities).

_____ You are not eligible for _____ FMLA leave and/or _____ CFRA leave because (only one reason need be checked, although you may not be eligible for other reasons):

_____ You have not met the 12-month length of service requirement under the FMLA and/or CFRA. As of the first date of requested leave, you will have worked approximately _____ months towards this requirement.

_____ You have not met the 1,250 hours worked requirement under the FMLA and/or CFRA.

_____ You do not work and/or report to a work site with 50 or more employees within a 75 mile radius.

_____ You have exhausted your _____ FMLA and/or _____ CFRA leave entitlement in the applicable 12-month period.

If you have any questions, refer to the FMLA/CFRA policies in the Personnel Rules or contact County Personnel.

PART B - Rights and Responsibilities

As explained in **Part A,** you meet the eligibility requirements for taking FMLA and/or CFRA leave and have FMLA and/or CFRA leave available to you in the applicable 12-month period. **However, in order for us to determine whether your absence qualifies as FMLA and/or CFRA leave, you must return the following information to us. You will have at least 15 calendar days from receipt of this notice in which to provide the information; additional time may be required in some circumstances).** If sufficient information is not provided in a timely manner, your leave may be delayed, denied, or not designated as FMLA and/or CFRA leave.

If the leave is for your own serious health condition, to care for a family member, a military qualifying exigency, or to care for a servicemember, you must provide sufficient certification to support your request for FMLA and/or CFRA leave. A certification form that sets forth the information necessary to support your request isenclosed.

_____ (Check if Applicable) Sufficient documentation to establish the required relationship between you and your family member.

_____ (Check if Applicable) Other information needed:

_____

_____

If your leave qualifies as FMLA and/or CFRA leave, you will have the following responsibilities while on leave:

Contact Payroll 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 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 the FMLA and/or CFRA leave, and recover these payments from you upon your return to work.

You will be required to use your available paid sick leave (if leave is for your own serious health condition), vacation, and other leave**balances** during your FMLA and/or CFRA absence. In addition, you have the option, but are not required, to use paid family sick leave where the leave is to care for your spouse , registered domestic partner , child or parent due to his/her serious health condition or to care for an injured or ill servicemember as stated above. This means that you will receive your paid leave and the leave will also be considered protected FMLA and/or CFRA leave and counted against your FMLA and/or CFRA leave entitlement. You will not be required to use leave balances if you are receiving wage replacement benefits like state disability insurance (SDI), paid family leave insurance (PFL), or workers' compensation benefits, but your leave will still be considered protected FMLA and/or CFRA leave. You may choose to coordinate these benefits with your leave balances. **Notify Payroll andyour department immediately if you receive any wage replacement benefits and state whether or not you wish to coordinate your leave balances with these benefits.** Wage replacement benefits you receive in combination with any leave balances you coordinate with these benefits may not exceed your regular weeklywages.

_____ (Check if Applicable) 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).

You will be required to follow your department's regular call-in proceduresto report any absences related to any required intermittent leave or leave on a reduced work schedule.

If the circumstances of your leave change and you are able to return to work earlier than the date you have stated, you will be required to notify us at least two (2) workdays prior to the date you intend to report for work.

If your leave qualifies as FMLA and/or CFRA leave, you will have the following **rights** while on FMLA and/or CFRA leave:

- You have a right under the FMLA and/or CFRA for up to 12 weeks of unpaid leave in a 12-month period calculated as the calendar year (January – December).

- 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 is measured forward from the first day of leave.

- 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 and/or CFRA leave. (If your leave extends beyond the end of your FMLA and/or CFRA entitlement, you do not have return rights under FMLA and/or CFRA.)

- If you do not return to work following FMLA and/or CFRA leave for a reason other than: (1) the continuation, recurrence, or onset of a serious health condition which would entitle you to FMLA and/or CFRA 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 and/or CFRA leave.

- If we have not informed you above that you must use accrued paid leave while taking your unpaid FMLA and/or CFRA leave, you have the right to have your sick leave, vacation, and/or other leave balances run concurrently with your unpaid leave entitlement, provided you meet any applicable requirements of County policies relating to such leaves. 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 and/or CFRA leave.

  For a copy of conditions applicable to sick/vacation/other leave, please refer to the County Personnel Rules and, if you are a member of a bargaining unit, the memorandum of understanding with your bargaining unit. These are available at the County's website (co.shasta.ca.us).

Once we obtain the information from you as specified above, we will inform you within five (5) business days whether your leave will be designated as FMLA and/or CFRA leave and count towards your annual FMLA and/or CFRA leave entitlement.

If you have any questions, please contact CountyPersonnel at 225-5515.

Attachments:

Notice to Employees of Rights & Responsibilities Under FMLA

Notice to Employees of Rights & Responsibilities under CFRA and/or Pregnancy Disability Leave Law

Certification Form(If Eligible for FMLA and/or CFRA Leave

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CERTIFICATION OF HEALTH CARE PROVIDER

FAMILY AND MEDICAL LEAVE ACT AND/OR CALIFORNIA FAMILY RIGHTS ACT

SECTION I: For Completion by Employer- Instructions to Employer

The Family and Medical Leave Act ("FMLA") and the California Family Rights Act ("CFRA") provide that an employer may require an employee requesting FMLA and/or CFRA leave because of a need for leave due to a serious health condition to submit a health care provider certification issued by the employee's health care provider or the health care provider of the employee's covered family member. Please complete **Section** I before giving this form to your employee.

1. Employer's name: _____

2. Employer contact: _____

3. Employee's job title: _____

4. Employee's regular work schedule: _____

5. Employee's supervisor's name and telephone number: _____

6. Employee's essential job functions: Please see attached job description and or list of essential job functions.

SECTION II: **For Completion by Employee - Instructions to Employee**

Please complete SectionII before giving this form to your health care provider. The FMLA and/or CFRA permit an employer to require that you submit a timely, complete, and sufficient health care provider certification to support a request for FMLA and/or CFRA leave due to your own serious health condition or to care for a spouse, registered domestic partner, child, or parent with a serious health condition. If requested by your employer, your response is required to obtain or retain the benefit of FMLA and/or CFRA protections. Failure to provide a complete and sufficient health care provider certification may result in a denial or delay of your FMLA and/or CFRA request, or non-designation of your leave as FMLA and/or CFRA leave. You have 15 calendar days to return this form.

Employee name: _____
First Middle Last

Employee must complete Questions 1 through 3 below if time off is needed to care for a spouse, registered domestic partner, child, or parent:

1. Name of family member for whom you will provide care:

_____
First Middle Last

2. Relationship of the family member to you: _____

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

3. State the care you will provide to your family member and an estimate of the time period during which care will be provided, including a schedule if leave is to be taken intermittently or on a reduced work schedule:

SECTION III: **For Completion by Health Care Provider - Instructions to Health CareProvider**

The employee identified in Section I has requested leave under the FMLA and/or CFRA for his or her serious health condition and/or to care for a covered family member. Please fully answer all of the questions 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 and/or CFRA coverage. Limit your responses to the condition for which the employee is seeking leave. Finally, please be sure to sign the form on the last page.

1. Patient's name (if different from employee):
2. Approximate date condition or need for treatment commenced [Note: The Health Care Provider is not to disclose the underlying diagnosis without the consent of the patient]:
3. Probable duration of medical condition or need for treatment.
4. Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility? No Yes

If so, provide dates of admission:

5. Date(s) you treated the patient for condition:
6. Will the patient need to have treatment visits at least twice per year due to the condition? No Yes
7. Was medication, other than over-the-counter medication, prescribed? No Yes
8. Was the patient referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)? No Yes. If so, state the expected duration of treatment:
9. The attached sheet describes what is meant by a "serious health condition" and "incapacity" under the law. Does the patient's condition qualify under any of the categories described? If so, please circle the appropriate category.

(1) (2) (3) (4) (5) (6)

Answer Questions 10 - 13 if the certification is for the serious health condition of the employee.

10. 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 and/or her job functions.

(a) If medical leave is required for the employee's absence from work because of the employee's own condition (including absences due to pregnancy or chronic condition), is the employee unable to perform work of any kind? No Yes

(b) If able to perform some work, is the employee unable to perform any one or more of the essential functions of the employee's position? No Yes

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

11. 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: _____

12. Will the employee (1) need intermittent leave to attend follow-up treatment appointments or (2) need to work part-time or on a reduced schedule because of the employee's medical condition? No Yes

(a) If so, are the treatments, or the reduced number of hours of work medically necessary? No Yes

(b) Estimate the number of treatments if any, including the treatment schedule and dates of any scheduled appointments and the time required for each appointment, including any recovery period: _____

(c) Estimate the part-time or reduced work schedule the employee needs, if any

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

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

(a) Is it medically necessary for the employee to be absent from work during the flare-ups? No Yes.

(b) 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

The following questions should only be answered if this certification is for the employee to care for a family member.]

14. (a) If leave is required to care for a spouse, registered domestic partner, child, , or parent of the employee with a serious health condition, does (or will) the family member require assistance for basic medical, hygiene, nutritional needs, safety, or for transportation? _____ No _____ Yes

(b) After reviewing the information provided by the employee in Section II (Item 3) above, does the patient's condition warrant the participation of the employee (This participation may include psychological comfort and/or arranging for third party care for the family member)? No Yes

(c) Estimate the period of time care is needed or during which the employee's presence would be beneficial:

---

15. Will the patient be incapacitated for a single continuous period of time, including any time for treatment and recovery? No Yes.

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

16. Will the patient require follow-up treatments, including any time for recovery? ___No_____Yes

Is it medically necessary for the employee to be off work for these follow-up treatments and recovery periods?

_____No_____Yes

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

17. Is it medically necessary for the employee to be off work on an intermittent or reduced schedule basis to provide care for the patient, including any time for recovery?

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

_____hour(s) per day _____days per week from_____through_____

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

Is it medically necessary for the employee to be absent from work to provide care during the flare-ups?_____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:_____hoursor_____day(s) per episode

_____ _____

Signature of Health Care Provider Type of Practice / Medical Specialty

_____ _____

Address City, State and Zip Code

_____ _____

Telephone Number Date

_____

Facsimile Number

_____

Employee's Signature

_____

Date

Attachment:
Essential Functions for Employee's Position

SERIOUS HEALTH CONDITION AND INCAPACITY

The term "incapacity" means inability to work, attend school, or perform other regular daily activities due to the serious health condition, treatment therefore or recovery there from.

A "Serious Health Condition" means an illness, injury, impairment, or physical or mental condition that involves one of the following:

1. Hospital Care

Inpatient care (i.e., an overnight stay) in a hospital, hospice, or residential medical facility, including any period of incapacity or subsequent treatment in connection with or consequent to such inpatient care.

2. Absence Plus Treatment

A period or incapacity of more than three consecutive calendar days (including any subsequent treatment or period of incapacity relating to the same condition), that also involves:

(1) Treatment two or more times within 30 days of the first day of incapacity, unless extenuating circumstances exist, by a health care provider, by a nurse or physician's assistant under direct supervision of a health care provider, or by a provider of health care services (e.g., physical therapist) under orders of, or on referral by, a health care provider; or

(2) Treatment by a health care provider on at least one occasion which results in a regimen of continuing treatment under the supervision of the health care provider.

3. Pregnancy [NOTE: An employee's own incapacity due to pregnancy is covered as a serious health condition under FMLA but not under CFRA.]

Any period of incapacity due to pregnancy, or for prenatal care.

4. Chronic Conditions Requiring Treatment

Any period of incapacity or treatment for such incapacity due to a chronic condition. A chronic condition is one which:

(1) Requires periodic visits (defined as at least twice a year) for treatment by a health care provider, or by a nurse or physician's assistant under direct supervision of a health care provider;

(2) Continues over an extended period of time (including recurring episodes of a single underlying condition); and

(3) May cause episodic rather than a continuing period of incapacity (e.g., asthma, diabetes, epilepsy, etc.)

5. Permanent/Long-term Conditions Requiring Supervision

A period of incapacity which is 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.

6. Multiple Treatments (Non-Chronic Conditions)

Any period of absence to receive multiple treatments (including any period of recovery

~~there from) by a health care provider or by a provider of health care services under orders of, or on referral by, a health care provider, either~~

~~(1) for restorative surgery after an accident or other injury, or~~

~~(2) for a condition that would likely result in a period of incapacity of more than three consecutive calendar days in the absence of medical intervention or treatment, such as cancer (chemotherapy, radiation, etc.), severe arthritis (physical therapy), kidney disease (dialysis).~~

DESIGNATION NOTICE

FAMILY AND MEDICAL LEAVE ACT AND/OR CALIFORNIA FAMILY RIGHTS ACT

DATE: _____

TO: _____

[Employee's Name and Title]

FROM: _____

[Department Manager]

SUBJECT: Designation Notice — Family and Medical Leave Act and/or California Family Rights Act

We have reviewed your request for leave under the Family and Medical Leave Act ("FMLA") and/or the California Family Rights Act ("CFRA") and any supporting documentation you have provided. In your request, you asked for FMLA and/or CFRA leave for the following reason:

_____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_____registered domestic partner (CFRA Leave Only)_____child_____parent due to his/her serioushealth condition.

_____Because of a qualifying exigency arising out of the fact that your_____spouse_____son or daughter_____parent is on active duty or called to active duty status in support of a contingency operation as a member of the National Guard or Reserves (FMLA Leave Only).

_____Because you are the_____spouse_____son or daughter_____parent_____next of kin of a covered servicemember with a serious injury or illness (FMLA Leave Only).

We have received your most recent information. Based on that information and the other information you provided, we have made the following determination(s):

_____**Your FMLA and/or CFRA leave request is approved. All leave taken for the specified reason will be designated as_____FMLA leave and/or_____CFRA leave (Check one or both as applicable).** Should you fail to return to work at the end of your FMLA and/or CFRA leave, or fail to provide continued certification of your need for additional leave, we cannot guarantee reinstatement to your prior position, or that any job will be available for you upon your return to work.

If you require intermittent leave or leave on a reduced work schedule, we will provide you with the leave your or your family member's health care provider indicates is necessary to the extent required by law. However, if your need for such leave is foreseeable based on planned medical treatment, we reserve the right to reassign you to a position with equivalent pay and benefits during your leave if another position is better suited to your new temporary schedule. We will notify you if a temporary reassignment will be made. You will be required to follow your department's regular call-in procedures to report any absence related to any required intermittent leave.

The FMLA and/or CFRA require that you notify us as soon as practicable if the dates of your 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 FMLA and/or CFRA leave entitlement:

_____ You currently have _____hoursof FMLA and/or_____hours of CFRA leave available.

_____ Your leave will begin on _____and end on _____

_____ Provided there is no deviation from your anticipated leave schedule, the following number of hours, days, or weeks will be counted against your _____FMLA and/or _____CFRA **(check one or both as applicable)**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 and/or CFRA 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 :

If you have requested to use paid leave during your FMLA and/or CFRA leave, any paid leave taken for this reason will count against your FMLA and/or CFRA leave entitlement.

You will be required to use your available paid sick leave (if leave is for your own serious health condition), vacation, and other leave**balances** during your FMLA and/or CFRA absence. In addition, you have the option, but are not required, to use paid family sick leave where the leave is to care for your spouse, registered domestic partner, child or parent due to his/her serious health condition or to care for an injured or ill servicemember as stated above. This means that you will receive your paid leave and the leave will also be considered protected FMLA and/or CFRA leave and counted against your FMLA and/or CFRA leave entitlement. However, you will not be required to use leave balances if you are receiving wage replacement benefits like state disability insurance (SDI), paid family leave insurance (PFL), or workers' compensation benefits. You may choose to coordinate these benefits with your leave balances. **Notify Payrolland your department immediately if you receive any wage replacement benefits and state whether or not you wish to coordinate your leave balances with these benefits.** Wage replacement benefits you receive in combination with any leave balances you coordinate with these benefits may not exceed your regular weekly wages.

Information about state disability insurance ("SDI") and paid family leave ("PFL") benefits are enclosed with this letter. It is your responsibility to apply for such benefits through the local Employment Development Department if you so choose.

If you are taking leave due to your own serious health condition and it is not intermittent or reduced schedule leave, you will be required to present a Fitness-for-Duty Certification 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 positionis attached. The Fitness-for-Duty Certification must address your ability to perform these functions.

_____ (Check if Applicable) If you are taking intermittent or reduced schedule leave due to your own serious health condition, you will be required to provide a Fitness-For-Duty Certification for such absences up to once every 30 days because it has been determined that reasonable safety concerns exist regarding your ability to perform your duties based on the serious health condition for which you are taking such leave. "Reasonable safety concerns" means a reasonable belief of significant risk of harm to you or to others, taking into consideration the nature and severity of the potential harm and the likelihood that potential harm will occur. Under this provision, for each subsequent instance of intermittent or reduced schedule leave, you will be required to submit a Fitness-for-Duty Certification unless one has already been submitted within the past 30 days. A list of the essential functions of your position is attached. The Fitness-For-Duty Certification must address your ability to perform these functions.

Additional information is needed to determine if your FMLA and/or CFRA leave request can be approved (check if applicable):

_____The certification you have provided is not (complete/sufficient) to determine whether the FMLA and/or

CFRA applies to your leave request. You must provide the following information no later than _____ (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 delayed, denied, or not designated as FMLA and/or CFRA leave:

_____

_____We are exercising our right to have you obtain a second or third opinion health care provider certification at our expense. Wewill provide further details at a later time.

_____Your FMLA leave request is denied.

_____ Your CFRA leave request is denied.

_____The FMLA does not apply to your leave request.

_____The CFRA does not apply to your leave request.

All additional information requested in this form should be directed to

_____

[Department Contact]

Any questions about FMLA and/or CFRA leave should be directed toCountyPersonnel.

Attachment:

Essential Functions of Position

Information about State Disability Insurance and Paid Family Leave Benefits

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NOTICE OF ELIGIBILITY AND RIGHTS AND RESPONSIBILITIES
FAMILY AND MEDICAL LEAVE ACT AND/OR PREGNANCY DISABILITY LEAVE

DATE: _____

TO: _____
[Employee's Name and Title]

FROM: _____
[Department Manager]

SUBJECT: Notice of Eligibility and Rights and Responsibilities — Family and Medical Leave Act and/or Pregnancy Disability Leave

PART A — Notice of Eligibility

We received information that you need leave beginning on _____ for your being disabled due to pregnancy, childbirth or related medical conditions.

This is to inform you that:

_____You are eligible for Pregnancy Disability Leave. (See **Part B** below for Rights and Responsibilities).

_____You are also eligible forFamily and Medical Leave ("FMLA"). (See **Part B** below for Rights and Responsibilities).

_____You 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 12-month length of service requirement under the FMLA. As of the first date of requested leave, you will have worked approximately_____ months towards this requirement.

_____You have not met the 1,250 hours worked requirement under the FMLA and/or CFRA.

_____You do not work and/or report to a work site with 50 or more employees within a 75 mile radius.

_____You have exhausted your_____FMLA leave entitlement in the applicable 12-month period.

If you have any questions, refer to the FMLA/ policies in the Personnel Rules or contact CountyPersonnel.

PART B - Rights and Responsibilities

As explained in **Part A,** you meet the eligibility requirements for taking Pregnancy Disability Leave and/or FMLA leave. **However, in order for us to determine whether your absence qualifies as Pregnancy Disability Leave and/or FMLA leave, you must return the following information to us. You will have at least 15 calendar days from receipt of this notice in which to provide the information; additional time may be required in some circumstances.** If sufficient information is not provided in a timely manner, your leave may be delayed, denied, or not designated as Pregnancy Disability Leave and/or FMLA leave.

Sufficient certification to support your request for Pregnancy Disability Leave and/or FMLA leave. A certification form that sets forth the information necessary to support your request isenclosed.

_____ (Check if Applicable): Additional information needed:

_____

_____

If your leave qualifies as Pregnancy Disability Leave and/or FMLA leave, you will have the following responsibilities while on leave:

If your leave qualifies as FMLA leave, contact Payroll to make arrangements to continue to make your share of the premium payments on your health insurance to maintain health benefits for 12 workweeks of leave. You have a minimum 30-day 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 the FMLA leave, and recover these payments from you upon your return to work.

You will be required to use your available paid sick leave during your Pregnancy Disability Leave and/or FMLA absence. In addition, you have the option, but are not required, to use vacation and other accrued leave balances. This means that you will receive your paid leave and the leave will also be considered protected Pregnancy Disability Leave and/or FMLA leave and counted against your Pregnancy Disability Leave and/or FMLA leave entitlement. You will not be required to use leave balances if you are receiving wage replacement benefits like state disability insurance (SDI), paid family leave insurance (PFL), or workers' compensation benefits, but your leave will still be considered Pregnancy Disability Leave and/or FMLA leave. You may choose to coordinate these benefits with your leave balances. **Notify Payrolland your department immediately if you receive any wage replacement benefits and state whether or not you wish to coordinate your leave balances with these benefits.** Wage replacement benefits you receive in combination with any leave balances you coordinate with these benefits may not exceed your regular weekly wages.

_____ (Check if Applicable) 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).

You will be required to follow your department's regular call-in proceduresto report any absences related to any required intermittent leave or leave on a reduced work schedule.

If the circumstances of your leave change and you are able to return to work earlier than the date you have stated, you will be required to notify us at least two (2) workdays prior to the date you intend to report for work.

If your leave qualifies as Pregnancy Disability Leave and/or FMLA leave, you will have the following **rights** while on Pregnancy Disability Leave and/or 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).
- You have a right under the Pregnancy Disability Leave law for up to four months of leave, depending on the periods of actual disability. The four months is defined as 88 work days for full-time employees working five (5) days per week; employees working other schedules are entitled to a pro-rata amount of leave.
- While on FMLA leave, your health benefits must be maintained during any period of unpaid leave under the same conditions as if you continued to work. This does not apply to Pregnancy Disability Leave that fails to also qualify as FMLA leave.
- 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 Pregnancy Disability Leave and/or FMLA leave. (If your leave extends beyond the end of your Pregnancy Disability Leave and/or FMLA entitlement, you do not have return rights under the Pregnancy Disability Leave law and/or 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; or (2) 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. This does not apply to Pregnancy Disability Leave that fails to also qualify as FMLA leave.

- If we have not informed you above that you must use accrued paid leave while taking your unpaid Pregnancy Disability Leave and/or FMLA leave, you have the right to have your sick leave, vacation, and/or other leave balances run concurrently with your unpaid leave entitlement, provided you meet any applicable requirements of County policies relating to such leaves. 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 Pregnancy Disability Leave and/or FMLA leave.

  For a copy of conditions applicable to sick/vacation/other leave, please refer to the County Personnel Rules and, if you are a member of a bargaining unit, the memorandum of understanding with your bargaining unit. These are available at the County's website (co.shasta.ca.us).

Once we obtain the information from you as specified above, we will inform you within five (5) business days whether your leave will be designated as Pregnancy Disability Leave and/or FMLA leave and count towards your Pregnancy Disability Leave and/or annual FMLA leave entitlement.

If you have any questions, please contact CountyPersonnel at 225-5515.

Attachments:

Notice to Employees of Rights & Responsibilities Under FMLA

Notice to Employees of Rights & Responsibilities under CFRA and/or Pregnancy Disability Leave Law

Certification Form

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CERTIFICATION OF HEALTH CARE PROVIDER

PREGNANCY DISABILITY LEAVE AND/OR FAMILY AND MEDICAL LEAVE ACT

SECTION I: For Completion by Employer- Instructions to Employer

The Pregnancy Disability Leave Law and the Family and Medical Leave Act ("FMLA") provide that an employer may require an employee requesting Pregnancy Disability Leave and/or FMLA leave because of a need for leave due to a serious health condition to submit a health care provider certification issued by the employee's health care provider.Please complete **Section** I before giving this form to your employee.

1. Employer's name: _____

2. Employer contact: _____

3. Employee's job title: _____

4. Employee's regular work schedule: _____

5. Employee's supervisor's name and telephone number: _____

6. Employee's essential job functions: Please see attached job description and or list of essential job functions.

SECTION II: **For Completion by Employee - Instructions to Employee**

Please complete SectionII before giving this form to your health care provider. The Pregnancy Disability Leave Law and the FMLA permit an employer to require that you submit a timely, complete, and sufficient health care provider certification to support a request for Pregnancy Disability Leave and/or FMLA leave due to your being disabled due to pregnancy, childbirth, or related medical conditions or your need for prenatal care. If requested by your employer, your response is required to obtain or retain the benefits of the Pregnancy Disability Leave law and/or FMLAprotections. Failure to provide a complete and sufficient health care provider certification may result in a denial or delay of your Pregnancy Disability Leave and/or FMLA request, or non-designation of your leave as Pregnancy Disability Leave and/or FMLA leave. You have 15 calendar days to return this form.

Employee name: _____
First Middle Last

SECTION III: **For Completion by Health Care Provider - Instructions to Health Care Provider**

The employee identified in SectionI has requested leave under the Pregnancy Disability Leave Law and/or the FMLA for a disability related to pregnancy, childbirth, or related medical conditions or for prenatal care. . Please fully answer all of the questions 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 Pregnancy Disability Leave and/or FMLA coverage. Limit your responses to the condition for which the employee is seeking leave. Finally, please be sure to sign the form on the last page.

1. Approximate date condition or need for treatment commenced [Note: The Health Care Provider is not to disclose the underlying diagnosis without the consent of the patient]: _____

2. Probable duration of medical condition or need for treatment. _____

3. Is the employee, because of her pregnancy (which includes pregnancy, childbirth, or related medical conditions), unable to perform work at all or is unable to perform any one or more of the essential functions of her position without undue risk to herself, the successful completion of her pregnancy, or to other persons? No Yes

4. 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 and/or her job functions.

(a) Is the employee unable to perform work of any kind? ____No ____Yes

(b) If able to perform some work, is the employee unable to perform any one or more of the essential functions of the employee's position without undue risk to herself, the successful completion of her pregnancy, or to other persons? ____No ____Yes

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

5. Will the employee be incapacitated for a single continuous period of time due to 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 (1) need intermittent leave to attend treatment appointments or prenatal care or (2) need to work part-time or on a reduced schedule because of the employee's medical condition? ____No ____Yes

(a) If so, are the treatments, or the reduced number of hours of work medically advisable? ____No ____Yes

(b) Estimate the number of treatments if any, including the treatment schedule and dates of any scheduled appointments and the time required for each appointment, including any recovery period: _____

(c) Estimate the part-time or reduced work schedule the employee needs, if any

_____hour(s) per day _____days per week from _____through _____

6. Will the condition cause episodic flare-ups periodically disabling the employee (including "morning sickness")? ___No ____Yes

(a) Is it medically advisable for the employee to be absent from work during the flare-ups? ___No ____Yes

(b) 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 disability 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

~~Signature of Health Care Provider~~ ~~Type of Practice / Medical Specialty~~

~~Address~~ ~~City, State and Zip Code~~

~~Telephone Number~~ ~~Date~~

~~Facsimile Number~~

~~Employee's Signature~~

~~Date~~

~~Attachment:~~
~~Essential Functions for Employee's Position~~

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DESIGNATION NOTICE

FAMILY AND MEDICAL LEAVE ACT AND/ OR PREGNANCY DISABILITY LEAVE

DATE: _____

TO: _____

[Employee's Name and Title]

FROM: _____

[Department Manager]

SUBJECT: Designation Notice — Family and Medical Leave Act/Pregnancy Disability Leave

We have reviewed your request for leave under the Family and Medical Leave Act ("FMLA") and/or Pregnancy Disability Leave law ("PDL") and any supporting documentation you have provided. In your request, you asked for FMLA and/or PDL for your being disabled due to pregnancy, childbirth, or related medical conditions.

We have received your most recent information. Based on that information and the other information you provided, we have made the following determinations:

_____ **Your _____ PDL and/or _____ FMLA leave request is approved. All leave taken for the specified reason will be designated as PDL leave.**

_____ **Twelve weeks of your PDL leave will also be designated as FMLA leave.**

Should you fail to return to work at the end of your PDL and/or FMLA leave, or fail to provide continued certification of your need for additional leave, we cannot guarantee reinstatement to your prior position, or that any job will be available for you upon your return to work.

If you require intermittent leave or leave on a reduced work schedule, we will provide you with the leave your health care provider indicates is necessary to the extent required by law. However, for the twelve weeks your leave may qualify as FMLA leave, and if your need for such leave is foreseeable based on planned medical treatment, we reserve the right to reassign you to a position with equivalent pay and benefits during your leave if another position is better suited to your new temporary schedule. We will notify you if a temporary reassignment will be made. You will be required to follow your department's regular call- in procedures to report any absence related to any required intermittent leave or leave on a reduced work schedule.

Please notify us as soon as practicable if the dates of your 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 FMLA and/or PDL leave entitlement:

_____ You currently have hours of PDL and/or hours of FMLA leave available.

_____ Your leave will begin on _____ and end on _____

_____ Provided there is no deviation from your anticipated leave schedule, the following number of hours, days, or weeks will be counted against your Pregnancy Disability 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 FMLA 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 PDL and/or FMLA entitlement at this time. If your leave qualifies as FMLA leave, 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:

If you have requested to use paid leave during your PDL and/or FMLA leave, any paid leave taken for this reason will count against your PDL and/or FMLA leave entitlement.

You will be required to use your available paid sick leave during your Pregnancy Disability Leave and/or FMLA absence. In addition, you have the option, but are not required, to use vacation and other accrued leave balances. This means that you will receive your paid leave and the leave will also be considered protected Pregnancy Disability Leave and/or FMLA leave and counted against your Pregnancy Disability Leave and/or FMLA leave entitlement. However, you will not be required to use leave balances if you are receiving wage replacement benefits like state disability insurance (SDI), paid family leave insurance (PFL), or workers' compensation benefits. You may choose to coordinate these benefits with your leave balances. **Notify Payroll<u>and</u> your department immediately if you receive any wage replacement benefits and state whether or not you wish to coordinate your leave balances with these benefits.** Wage replacement benefits you receive in combination with any leave balances you coordinate with these benefits may not exceed your regular weekly wages.

Information about state disability insurance ("SDI") and paid family leave ("PFL) benefits are enclosed with this letter. It is your responsibility to apply for such benefits through the local Employment Development Department if you so choose. Please inform Payroll immediately if/when you receive SDI or PFL benefits so as to avoid any sort of overpayment that could occur as a result of your choosing to coordinate leave balances with SDI or PFL benefits.

If you are not taking intermittent or reduced schedule leave, you will be required to present a Fitness-for-Duty Certification 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 attached. The Fitness-for-Duty Certification must address your ability to perform these functions.

_____ (Check if Applicable) If you are taking intermittent or reduced schedule leave, you will be required to provide a Fitness-For-Duty Certification for such absences up to once every 30 days because it has been determined that reasonable safety concerns exist regarding your ability to perform your duties based on the condition for which you are taking such leave. "Reasonable safety concerns" means a reasonable belief of significant risk of harm to you or to others, taking into consideration the nature and severity of the potential harm and the likelihood that potential harm will occur. Under this provision, for each subsequent instance of intermittent or reduced schedule leave, you will be required to submit a Fitness-for-Duty Certification unless one has already been submitted within the past 30 days. A list of the essential functions of your position is attached. The Fitness-For-Duty Certification must address your ability to perform these functions.

Additional information is needed to determine if your FMLA and/or PDL leave request can be approved (check if applicable):

_____ The certification you have provided is not complete and/or sufficient to determine whether the PDL and/or FMLA applies to your leave request. You must provide the following information no later than _____ (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 delayed, denied, or not designated as PDL and/or FMLA leave:

_____

_____

_____

_____

_____ In connection with FMLA leave (but not PDL Leave) we are exercising our right to have you obtain a second or third health careprovider certification at our expense. We will provide further details at a latertime.

_____

_____ Your FMLA Leave request is denied.

_____Your PDL Leave request is denied.

_____The FMLA does not apply to your leave request.

_____ The PDL does not apply to your leave request.

All additional information should be directed to:

_____
[Department Contact]

Any questions about FMLA and/or PDL leave should be directed to CountyPersonnel.

Attachment:

_____ Essential Functions of Employee's Position

_____ Information about State Disability Insurance and Paid Family Leave Benefits

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CERTIFICATION FOR SERIOUS INJURY OR ILLNESS OF COVERED SERVICEMEMBER - MILITARY FAMILY LEAVE

FAMILY AND MEDICAL LEAVE ACT

SECTION I: For Completion By Employee and/or Covered Servicemember for Whom the Employee Is Requesting Leave: (This section must be completed before any of the below sections can be completed by a health care provider.)

Please complete SectionI before having SectionII completed. The Family and Medical Leave Act ("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. Failure to do so may result in a denial or delay of your FMLA request, or non-designation of your leave as FMLA leave. You must be given at least 15 calendar days to return this form to your employer.

PART A: Employee Information

Name and address of the employer (this is the employer of the employee requesting leave to care for a covered servicemember):

_____

Name of employee requesting leave to care for a covered servicemember:

_____

First Middle Last

Name of the covered servicemember (for whom employee is requesting leave to care):

_____

First Middle Last

Relationship of employee to covered servicemember for whom employee will be providing 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 to which the servicemember is currently assigned:

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 (TDR)?_____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 authorizedprivate 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.

The employee listed on the previous page 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 and 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. Please answer all applicable parts fully and completely. 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 seekingleave.

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) The covered servicemember's medical condition is classified as (check one of the following):

_____ **(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.)

_____ **(S1) 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." If such leave is requested, you may be required to complete a health care provider certification form.)

(2) Was the condition for which the covered servicemember is being treated incurred in the line of duty on active duty in the Armed Forces?_____Yes_____No

(3) Approximate date condition commenced:_____

(4) Probable duration of condition and/or need for care:_____

(5) Is the covered servicemember undergoing medical treatment, recuperation, or therapy?
_____Yes_____No.

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 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 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:**_____

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CERTIFICATION OF QUALIFYING EXIGENCY - MILITARY FAMILY LEAVE

FAMILY AND MEDICAL LEAVE ACT

SECTION I: For Completion by Employer

Employer name: _____

Contact information: _____

SECTION II: For Completion by Employee - Instructions to Employee

Please complete Section II fully and completely. The Family and Medical Leave Act ("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. While you are not required to provide this information, failure to do so may result in a denial or delay of your request for FMLA leave or non-designation of your leave as FMLA leave. Your employer must give you at least 15 calendar days to return this form.

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.

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 4hours):

   Frequency: _____ timesper _____ week(s) _____ month(s)

   Duration: _____ hours _____ day(s) per event

PART C: Third-Party Meeting Information

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 organization), 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: Certification

I certify that the information I provided above is true and correct.

_____ _____

Signature of Employee Date

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County-Provided Mobile Data Device Agreement

It is the responsibility of the employee who is connecting to the County network to ensure that all components of his/her connection remain as secure as his/her network access within the County. It is imperative that any wired (via sync cord, for example) or wireless connection, including, but not limited to devices and service, used to conduct County business be utilized appropriately, responsibly, and ethically. Failure to do so will result in immediate suspension of employee's connection to County network. For the purposes of this agreement, Mobile Data Device includes, but is not limited to, devices such as smartphones, iPads, and other tablet devices, hereinafter referred to as 'device'.

The following rules must be observed by employee:

1. The types of devices that are allowed to connect to the County network are limited. Please check with Shasta County Information Technology (CountyIT) to determine the current devices and software versions that are supported. Prior to initial use for connecting to the County network, employee must execute this agreement and verify with County IT that all hardware, software and related services are compatible with the County network.

2. Some devices may require the purchase of a software application (app) to allow the device to comply with County IT mandated security requirements. If software applications are required, the department requesting connection of the County provided device will be responsible for making this purchase prior to the device being connected to the County network. The employee's department is responsible for all costs of required software applications. Additionally, it is the employee's department's responsibility to set up the employee's individual calling plan with a cell phone provider and to pay all charges incurred. Any service issues or billing disputes with the carrier or vendor are the sole responsibility and obligation of the employee's department.

3. Employees who access, via his/her device, Protected Health Information (PHI), and/or Personally Identifiable Information (PII), and/or any other data deemed by policy or statute to require encryption, are required to maintain the settings on his/her device such that data encryption is enabled at all times.

4. Employee agrees that he/she has no reasonable expectation of privacy concerning any and all of the information stored on a county provided device. The County reserves the right to review and access at any time any and all of the information stored on county provided devices, including, but not limited to, wireless devices, which are used to connect to county resources, such as email. Employee also agrees to and accepts that his/her access and/or connection to the County network may be monitored to record dates, times, duration of access, etc., in order to identify unusual usage patterns or other suspicious activity in order to identify accounts or systems that may have been compromised by external parties. When an employee voluntarily accepts a County provided device, the County has the right and the ability to review and access any and all information on that device, including data the employee may view as personal. Should employee wish to stop using a County provided device, employee shall return the County provided device. Any employee who refuses to surrender a county provided device when requested by his or her supervisor may be subject to disciplinary action.

5. Employees accessing any County network with mobile data devices, are required to know and adhere to all County policies and guidelines, including policies and procedures concerning the confidentiality of the data being accessed and personal activities during work hours.

6. Any and all data obtained via the County network remains the property of the County in perpetuity.

7. Passwords and other confidential data are not to be stored on any associated storage devices such as Secure Digital (SD) and Compact Flash (CF) cards, as well as Memory Sticks and related flash-based supplemental storage media.

8. Employees who dispose of their device or return it to the vendor must remove all County information from the device before disposing of it or returning it to the vendor. Employees can contact County IT (245-7575) if he/she needs assistance in removing County information from his/her device.

9. Employees must immediately report a missing, replaced, or stolen device to the CountyIT (245-7575) and to their cell carrier. County IT will send a "KILL" command that will clear **ALL** data from the device and return the device to the configuration it was in when originally issued from the cell carrier.

10. For County provided devices where the department permits the employee to store personal data, settings, media, or applications on the device, it is the employee's responsibility to back up his/her personal data, settings, media, or applications so that he/she can recover his/her personal data in the event the device has to be "KILLED" by County IT.

11. The device is subject to a remote "KILL" under the following conditions:

    - Lost or stolen device.
    - Six consecutive failed password attempts (assumes the device is no longer in the owner's possession).
    - Employee leaves the employ of the County.
    - Department Head request.
    - County IT determines that any access to the County network is at risk (subject to approval by the Chief Information Officer).

12. The employee must abide by all municipal, state and federal laws concerning the use of mobile devices.

13. The County provided device will be forced to comply with complex password policies. This means that to use the device, the employee will have to unlock it by entering the valid password. Additionally, password changes will be required as determined by County IT. Devices will automatically lock (requiring the user to re-enter his/her password) after 10 minutes of inactivity. Employee agrees not to divulge passwords to others (see Section 26.2 Acceptable Use Policy in the Personnel Rules).

14. County IT will charge the employee's department the current IT Professional Service hourly rate for all support of devices connected to the County network. The employee must follow his/her department's procedures for obtaining services from County IT.

I have read, received a copy, and agree to abide by the foregoing County-Provided Mobile Device Agreement and Personnel Rule 26.12, Mobile Data Device Policy. I understand that any failure to comply with this agreement may result in the suspension of any or all remote access privileges.

Employee Name	Employee Signature	Date	Employee's Department

Department Head, or his/her designee	Department Head, or his/her designee, Signature	Date

Forward completed form to: Chief Information Officer
Mail Code IS203A

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Personal Mobile Data Device Agreement

It is the responsibility of the employee who is connecting to the County network to ensure that all components of his/her connection remain as secure as his/her network access within the County. It is imperative that any wired (via sync cord, for example) or wireless connection, including, but not limited to devices and service, used to conduct County business be utilized appropriately, responsibly, and ethically. Failure to do so will result in immediate suspension of employee's connection to County network. For the purposes of this agreement, Mobile Data Device includes, but is not limited to, devices such as smartphones, iPads, and other tablet devices, hereinafter referred to as 'device'.

The following rules must be observed by employee:

1. The types of devices that are allowed to connect to the County network are limited. Please check with Shasta County Information Technology (County IT) to determine the current devices and software versions that are supported. Prior to initial use for connecting to the County network, employee must execute this agreement and verify with County IT that all hardware, software and related services are compatible with the County network.

2. Some devices may require the employee to purchase a software application (app) to allow the device to comply with County IT mandated security requirements. Employee must receive prior approval from County IT before installing any software application in order to ensure software and device comply with County mandated security requirements. Employee is responsible for all costs of required software applications. Additionally, it is the employee's responsibility to set up his/her individual calling plan with his/her cell phone provider and to pay all charges incurred. Any service issues or billing disputes with the carrier or vendor are the sole responsibility and obligation of the employee.

3. Employees who access, via his/her device, Protected Health Information (PHI), and/or Personally Identifiable Information (PII), and/or any other data deemed by policy or statute to require encryption, are required to maintain the settings on his/her device such that data encryption is enabled at all times.

4. By voluntarily connecting a personal device to County resources, Employee agrees that he/ she has no reasonable expectation of privacy concerning any and all of the information stored on his/her device. The County reserves the right to review and access at any time any and all of the information stored on personal devices, including, but not limited to, wireless devices, which are used to connect to county resources, such as email. Employee also agrees to and accepts that his/her access and/or connection to the County network may be monitored to record dates, times, duration of access, etc., in order to identify unusual usage patterns or other suspicious activity in order to identify accounts or systems that may have been compromised by external parties. When an employee voluntarily connects a personal device to County resources, the County has the right and the ability to review and access any and all information on the employee's personal device, including data the employee may view as personal. The County's right and ability to review and access any and all information on that personal device exists for the entire time the employee uses the device to connect to County resources. Should employee wish to terminate the connection to County resources, employee shall submit the personal

device for access and review by County to ensure that all County related information is removed from the personal device. Any employee who refuses to surrender a personal device connected to County resources when requested by his or her supervisor to access and review the information on the device may be subject to disciplinary action.

5. Employees accessing any County network with personal devices, are required to know and adhere to all County policies and guidelines, including policies and procedures concerning the confidentiality of the data being accessed and personal activities during work hours.

6. Any and all data obtained via the County network remains the property of the County in perpetuity.

7. Passwords and other confidential data are not to be stored on any associated storage devices such as Secure Digital (SD) and Compact Flash (CF) cards, as well as Memory Sticks and related flash-based supplemental storage media.

8. Employees who dispose of their device or return it to the vendor must remove all County information from the device before disposing of it or returning it to the vendor. Employees can contact County IT (245-7575) if they need assistance in removing County information from the employee's device.

9. Employees must immediately report a missing, replaced, or stolen device to the CountyIT (245-7575) and to their personal cell carrier. County IT will send a "KILL" command that will clear **ALL** data from the device and return the device to the configuration it was in when originally issued from the cell carrier.

10. It is the employee's responsibility to back up his/her personal data, setting, media, or applications on the device so that he/she can recover his/her personal data, settings, media, or applications in the event the device has to be "KILLED" by County IT.

11. The device is subject to a remote "KILL" under the following conditions:

    - Lost or stolen device.
    - Six consecutive failed password attempts (assumes the device is no longer in the owner's possession).
    - Employee leaves the employ of the County.
    - Department Head request.
    - County IT determines that any access to the County network is at risk (subject to approval by the Chief Technology Officer).

12. The employee must abide by all municipal, state and federal laws concerning the use of mobile devices.

13. The employee's device will be forced to comply with complex password policies. This means that to use the device, the employee will have to unlock it by entering the valid password. Additionally, password changes will be required as determined by County IT. Devices will automatically lock (requiring the user to re-enter his/her password) after 10 minutes of inactivity. Employee agrees not to divulge passwords to others (see Section 26.2 Acceptable Use Policy in the Personnel Rules).

~~14.~~

15~~5~~. County IT will charge the employee's department the current IT Professional Service hourly rate for all support of personal devices connected to the County network. The employee must follow their department's procedures for obtaining services from County IT.

I have read, received a copy, and agree to abide by the foregoing Personal Mobile Device Agreement and Personnel Rule 26.12, Mobile Data Device Policy. I understand that any failure to comply with this agreement may result in the suspension of any or all remote access privileges.

Employee Name	Employee Signature	Date	Employee's Department

Department Head, or his/her designee	Department Head, or his/her designee, Signature	Date

Forward completed form to: Chief Technology Officer
Mail Code IS203A