# APPENDIX P

# SUSPECTED CHILD ABUSE & NEGLECT (SCAN) INFORMATION

United States Department of the Interior

BUREAU OF INDIAN AFFAIRS
Washington, D.C. 20245

IN REPLY REFER TO:
Personnel Management 2

JUN 5 1992

Memorandum

To: Aberdeen Area Office
Anadarko Area Office
Navajo Area Office
Phoenix Area Office
Portland Area Office
Attn: Personnel Officers

From: ACTING Director, Office of Management and Administration

Subject: Notification of the BIA/NFFE Sick Leave Bank Program Existence

The Sick Leave Bank Program is in existence as of date of this memorandum.

In accordance with the negotiated supplemental agreement of the Implementation Procedures for the Sick Leave Bank Program dated August 30, 1991, Section (N), Notification, states in part that:

> "Management will inform bargaining unit contract education employees on a one time basis that the sick leave bank is in existence."

The supplemental agreement was approved by the Director of Personnel on October 24, 1991. The published implementation procedures for the sick leave bank and the software program for tracking the sick leave bank program were developed and reviewed by the NFFE union and the OIEP representatives for distribution.

Each Area Office will receive copies of the sick leave bank implementation procedures and a copy of the computer sick leave bank program. The number of copies sent to each Area Office were based on the estimated need for distribution. Please note that the copies of the procedures are available in limited quantities. This is due to the expense of publication and the projected need by the applicable parties. Therefore, copies of the implementation procedures should be distributed on an as needed basis. If certain sections are needed by an employee (i.e. Donor Application), those sections should be copied and provided.

The attached computer sick leave bank program should be copied or a "backup disk" made in case of a computer operating accident. Keep the "backup disk" in a safe place. The Area offices will make copies of the computer program as needed for site distribution.

Attached also is a Memorandum that may be used to notify the bargaining unit contract education employees that the sick leave bank is in existence. To preclude any prospective donor from forfeiting excess sick leave that may otherwise be donated, this notification or one similar to it should be circulated immediately.

If you have any question regarding contract provisions or implementation procedures, please contact Mr. Robert Andres on FTS/Commercial (202) 208-2540. If you have questions regarding the computer program, contact Mr. Ed Vocke on FTS/Commercial (202) 208-7111.

Attachments (disk under separate cover)

TABLE OF CONTENT

A. PURPOSE OF THE SICK LEAVE BANK:

The purpose of the sick leave bank is to provide a voluntary sick leave bank program in which unused accrued sick leave of Office of Indian Education Program (OIEP) bargaining unit contract education employees may be donated to the sick leave bank for use by other OIEP bargaining unit contract education employees who qualify as needing sick leave due to injury or illness. Injury or illness herein is defined as a medical condition of an employee which is likely to result in the employee's absence from work for a period of time that will further result in loss of income to the employee because of non-availability of personal sick leave.

Article 40, Education Personnel System, Section 1, Employment and Section 8, Sick Leave Bank of the current negotiated agreement between the Department of the Interior, Bureau of Indian Affairs and the National Federation of Federal Employees of the Bureau of Indian Affairs Consolidated Locals are incorporated in this agreement by reference.

B. DEFINITIONS:

Accrued Sick Leave: sick leave that has been credited to the recipient either while working or while using sick leave from the sick leave bank.

Contract Educator: an individual who is contracted under the provision of P.L. 95-561, whose services are required or who is employed in an education position and who is also referred to as employee for purposes of implementing a sick leave bank.

Employee: bargaining unit contract education employee (BUCEE) under the authority of P.L. 95-561 are recognized as employees of the Bureau of Indian Affairs.

Leave Year: extends from the 1st day of the school term to the day before the 1st day of the next school year term.

Sick Leave Bank Donor or Donor: an employee who contributes sick leave to the sick leave bank.

Sick Leave Bank Recipient or Recipient: an employee who has made application and been approved for sick leave from the sick leave bank.

Site: the physical location of the school.

Sick Leave Bank or Bank: a pooled fund of sick leave for the use of the employees at the site that it was established.

Injury & Illness: has the meaning given that term in Section (A) of this document.

Sick Leave Bank Committee or Committee: employees at the site who serve to review and take action on applications for sick leave at the sick leave bank.

C. HOW TO ESTABLISH A SICK LEAVE BANK COMMITTEE:

* There will be no more than one sick leave bank committee per sick leave bank.

* There will be a three member committee that will preside over each sick leave bank. The committee will consist of ~~two~~ 1 management appointed representatives and ~~one~~ 2 union appointed representative. Each committee position will be a three year staggered appointment with the exception of the terms for the first appointment. The first appointment will be for 1, 2, and 3 years. Management's first appointment will be for 1 and 2 years, and the union will hold the initial 3 year appointment. If a committee member is absent from the work place, the two remaining committee members will constitute a quorum.

Among its duties the Committee will:

1. Establish internal decision making procedures.
2. Review, approve, and disapprove applications.
3. Monitor the status of each recipients injury or illness.
4. Monitor leave in the bank and the number of applications received.
5. Maintain an adequate amount of sick leave in the bank to the extent possible.

* Sick leave may not be borrowed, contributed to, or otherwise transferred between sick leave banks or between donor and recipient.

* There will be no more than one sick leave bank established per site. Sick leave and the committee's authority does not extend beyond the boundaries of the site.

D. HOW TO BECOME A SICK LEAVE BANK RECIPIENT:

The potential recipient makes application for sick leave to the sick leave bank on the prepared form entitled, Application Request for Recipient Under The Sick Leave Bank Program. The applicant signs and dates the application.

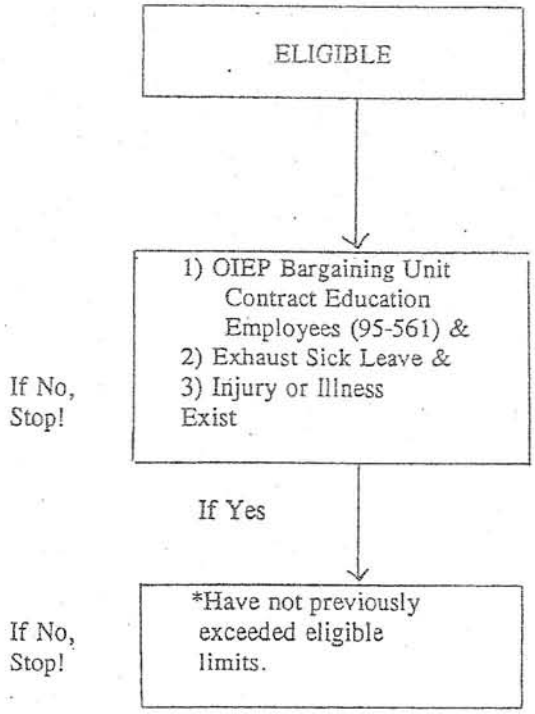
The applicant submits the application to the immediate supervisor who submits the application to the designated sick leave bank committee at the site. The committee will review the application based on the established criteria for approval or denial of an application and on the information provided on the application. The committee will notify the applicant within 7 calendar days from the date of receipt of the application of its action.

If the applicant's request for sick leave is denied by the committee, a written explanation on the space provided for on the application will be returned to the applicant. Denial of application for sick leave from the sick leave bank is not grievable. If the applicant's request is approved by the committee, the committee will so note in the appropriate space provided on the application along with the total number of hours that the applicant is entitled. The committee will sign and date and forward a copy of the application to the applicant, the Local Administrative Office, the applicant's immediate supervisor, and the timekeeper. Employees must follow normal leave procedures to request the use of the committee approved sick leave.

From the first day that the recipient begins to use the approved sick leave from the sick leave bank, the timekeeper will record and track the total number of hours used per pay period and keep a current balance of the hours used per pay period and keep a current balance of the hours that remain from the original approved sick leave bank hours. The timekeeper has the authority to charge the sick leave bank up to the total number of hours approved by the committee for the named recipient without any further action by the committee. Payroll will be alerted to the sick leave deduction through a notation in the remark section of the T & A sheet that the timekeeper charged the sick leave to the sick leave bank. These hours will be coded as regular time (hour code 010) on the time and attendance.

This procedure will continue until all the sick leave approved for the recipient has been exhausted or the sick leave has been returned to the sick leave bank.

SICK LEAVE BANK ELIGIBILITY




NOTE: All of the above conditions must apply in order for applicants to be eligible for the sick leave bank.

* Eligible limits are those in accordance with the negotiated agreement as follows in Article 40, Section 8(B)(1), (2), & (3):

"(1) Leave for Non-Long Term Illness or Injury. Eligible employees will receive up to 20 hours of sick leave from this bank during each six month interval for non-long term illness or injury.

(2) Leave for Long Term Illness and Injury. Eligible employees will receive 40 hours of sick leave from this bank for every three weeks incapacitated due to long term illness or injury.

(3) Sick Leave Bank for Maternity. Employees absent for normal maternity reasons shall be eligible to receive 40 hours of sick leave from the bank upon exhaustion of both sick, annual, and personal leave."

## SICK LEAVE BANK ELIGIBILITY

The prospective recipient must meet ALL the following requirements to be eligible for consideration for receiving donated leave.

1. MUST be an OIEP bargaining unit contract education employee (P.L. 95-561).

2. MUST have exhausted all sick leave.

3. MUST have an injury or illness supported by an acceptable medical certificate or statement.

4. MUST not have previously exceeded eligibility limits as provided for in the negotiated agreement as follows in Article 40, Section 8(B)(1), (2), & (3):

   "(1) Leave for Non-Long Term Illness or Injury. Eligible employees will receive up to 20 hours of sick leave from this bank during each six month interval for non-long term illness or injury.

   (2) Leave for Long Term Illness or Injury. Eligible employees will receive 40 hours of sick leave from this bank for every three weeks incapacitated due to long term illness or injury.

   (3) Sick Leave Bank for Maternity. Employees absent for normal maternity reasons shall be eligible to receive 40 hours of sick leave from the bank upon exhaustion of both sick, annual, and personal leave."

# APPLICATION REQUEST FOR RECIPIENT UNDER THE SICK LEAVE BANK PROGRAM

TO BE COMPLETED BY APPLICANT

| 1. Application's Name (Last, First, Middle) | 2. Social Security Number | 3. Date of Birth |
|---|---|---|
| 4. Position Title, Pay Plan, and Grade/Pay Level | 5. Are you a OIEP Contract Educator? YES ☐ NO ☐ | 6. Work Telephone Number |
| 7. Name of Organization (Agency, Department, Office, Division, Branch, etc.) | | 8. Payroll Office Number |
| 9. Are you affected by Medical Emergency? YES ☐ NO ☐ | 10. Date Medical Emergency Began | 11. Date Medical Emergency Ended or is Expected to End |

12. Nature and Severity of the Medical Emergency

13. Name of Physician Who Will Verify the Medical Emergency [Attach documentation from the physician (or other appropriate expert) showing the diagnosis, prognosis, and duration of the illness].

| 14. What is the Applicants Leave Balance of End of Last Pay Period? | 15. How Many Hours of Leave Without Pay Have Been Used for This Medical Emergency? | |
|---|---|---|
| 16. Name of Individual Completing the Application (If Applying on Behalf of the Applicant. | Relationship to Applicant | Telephone Number |
| 17. Signature of Applicant or Individual Applying on Behalf of Applicant (I certify that the Above Statements are True) | | Date Signed |

PRIVACY ACT STATEMENT: Participation in this program is voluntary. The information furnished will be used to identify records properly associated with the application to become a leave recipient. It may also be disclosed to a national, State, or local law enforcement agency where there is an indication of a violation or potential violation of civil or criminal law, rule, or regulation; or to another agency or court where the Government is party to a suit. Executive Order 9397 (November 22, 1943) authorizes use of the Social Security Number (SSN). Furnishing the Social Security Number, as well as other data, is voluntary, but failure to do so may delay or prevent action on the application.

COMMITTEE USE ONLY

Approved ☐ Denied ☐

Date Received:
Date of Action:
Notification Referred:
Total Number of Hours Approved:

Reason for Denial: _____

Committee Member Signatures: _____ Date: _____

_____ Date: _____

_____ Date: _____

TIMEKEEPER USE ONLY (FOLLOW-UP)

Sick Leave Used:

| Date | Pay Period | Used | Balance |
|---|---|---|---|

Sick Leave Returned:

| Date | Balance | Reason |
|---|---|---|

E. HOW TO BECOME A SICK LEAVE BANK DONOR:

The sick leave bank donor may donate no more than 120 hours in the course of the contract year and must be in accordance with Article 40, Section 8, BIA's and NFFE's negotiated agreement.

The donor makes application to donate only sick leave not annual leave to the sick leave bank on the prepared form entitled APPLICATION REQUEST TO DONATE SICK LEAVE TO THE SICK LEAVE BANK. The donor signs and dates the form to the effect that the content of the form has been read and understood.

The request is submitted by the donor to the immediate supervisor who submits the request to the designated sick leave bank committee at the site. The committee reviews the application and based on the established criteria for approval or denial of an application, notifies the applicant by copy of the notation on the application within 7 calendar days from the date of receipt of the application of committee's action. The committee will sign and date all actions.

If the committee approves the application, the application is then submitted to the Local Administrative Office. The Local Administrative Office sends a memorandum to payroll requesting that the sick leave of the designated donor be reduced in the amount specified. Payroll makes the adjustment in the donors sick leave hours.

# APPLICATION REQUEST TO DONATE SICK LEAVE TO THE SICK LEAVE BANK PROGRAM

I request that sick leave be transferred to the sick leave bank. As of the date indicated below, I have enough leave in my account to cover this amount. The amount of leave I am transferring also is not more than half the hours I will earn this year 120 hours.

I understand that my decision to transfer leave is not revocable.

I have not been directly or indirectly intimidated, threatened or coerced, or promised any benefit by any employee for the purpose of donating or using leave.

PRIVACY ACT STATEMENT: This program is voluntary. The information furnished will be used to identify records properly associated with the leave donation. It may also be disclosed to a national, State, or local law enforcement agency where there is an indication of a violation or potential violation of civil or criminal law, rule, regulation; or to another agency or court when the Government is party to a suit. Executive Order 9397 (November 22, 1943) authorizes use of the Social Security Number (SSN). Furnishing the Social Security Number, as well as other data, is voluntary, but failure to do so may delay or prevent action on the request to donate leave.

TO BE COMPLETED BY LEAVE DONOR

| 1. Name (Last, First, Middle) | 2. Social Security Number | 3. Date of Birth |
|---|---|---|
| 4. Position Title, Pay Plan, and Grade/Pay Level | 5. Are you a OIEP Contract Educator? YES ☐ NO ☐ | 6. Work Telephone Number |
| 7. Name of Organization (Agency, Department, Office, Division, Branch, etc.) | | |
| 8. Amount of Sick leave as of End of Last Pay Period | 9. Amount of Sick Leave To Be Transferred to the Sick Leave Bank | |
| 10. Site of Sick Leave Bank Where Leave is Being Donated | | |
| 11. Signature (I Certify that I have Read and Understand the Above Statements to be True) | | Date Signed |

COMMITTEE USE ONLY

APPROVED ☐ DATE: _____

DENIED ☐ DATE: _____

| Date Received: |
|---|
| Notification Referred: |
| Total # of Hours Transferred: |

Reason for Denial: _____

Committee Member Signatures: _____ Date: _____

_____ Date: _____

_____ Date: _____

F. LIMITATIONS TO DONORS:

Those limitations that are provided for in Article 40 of the negotiated agreement will apply.

Any portion of the sick leave that has been donated by an individual, will be irretrievable and wil remain in the sick leave bank to be used by other qualified applicants.

G. APPROVAL OF APPLICATION FOR SICK LEAVE:

The committee members established at each site in accordance with Article 40, Section 8(D) shall review applications for the sick leave recipients to determine if the person is eligible by a "injury or illness".

Before approving an application, the committee shall determine that the potential recipient has depleted their sick leave; that a injury or illness exists; and the applicant is a OIEP bargaining unit contract education employee.

If the application is approved the applicant will be notified by receipt of a copy of his/her application within 7 calendar days from the committee's logged receipt of the application.

If not approved, the applicant will be notified by receipt of his/her application within 7 calendar days from the committee's logged receipt of the application and the reasons for disapproval.

H. USE OF SICK LEAVE FROM THE SICK LEAVE BANK:

The recipient must have exhausted all accrued sick leave before they will be considered eligible for leave in the sick leave bank. Approval and use of the transferred leave will be done in accordance with the NFFE Agreement, Article 40, Section 8.

Transferred sick leave may not be transferred from one recipient to another. Any unused sick leave will be transferred back to the sick leave bank for redistribution by the committee.

Transferred sick leave will not be factored into the calculation for any lump sum payment for any settlement that might be due the recipient. Neither will sick leave from the bank be credited to an employee upon returning to work, but the unused portion will be returned to the sick leave bank.

If sick leave is not used within six (6) pay periods it will be returned to the sick leave bank.

I. TERMINATION OF SICK LEAVE BANK ELIGIBILITY:

Sick leave bank eligibility will be terminated when an employee's contract educators status changes or when an employee leaves the federal service.

When the committee receives a written notification from the recipient or a representative of that recipient that the injury or illness no longer exists, such leave eligibility will terminate. It will be effective at the end of the next bi-weekly pay period.

When the injury or illness no longer applies, no more requests will be accepted by the recipient and all unused sick leave will be restored back to the sick leave bank.

J. STATEMENT OF PROHIBITION OF COERCION:

An employee may not directly or indirectly intimidate, threaten, or coerce, or attempt to intimidate, threaten, or coerce, any other employee for the purpose of interfering with any right such employee may have with respect to freely choosing to contribute or not contribute and/or use or withdraw of sick leave as it relates to the sick leave bank.

K. RECORD KEEPING AND REPORTS

Each committee will maintain records and reports which reflects the current status of the bank from which to evaluate the continuation of the sick leave bank.

Each committee will, as provided for herein, provide and keep timely and accurate reports, certification, and records for review for the continuation of the sick leave bank program. This means that the forms entitled APPLICATION REQUEST FOR RECIPIENT UNDER THE SICK LEAVE BANK PROGRAM; APPLICATION REQUEST TO DONATE SICK LEAVE TO THE SICK LEAVE BANK PROGRAM; SITE MANAGEMENT SEED HOURS; COMMITTEE CERTIFICATION; and COMMITTEE SICK LEAVE BANK BY-WEEKLY LOG; shall be maintained at each site in three year increments. The original form entitled APPLICATION REQUEST TO DONATE SICK LEAVE shall be attached to the individual employee's time and attendance (T & A) report for the pay period during which the request was made. A copy of that form will remain on record with the committee.

(Sample copies of the above referenced forms follow in this section.)

## SITE MANAGEMENT SEED HOURS

Site Name: _____

Total Number of Bargaining Unit Contract Education Employees on 1st Day of School Term _____

- Donation 1/2 hr/per employee per sick leave year _____
- Total number of donated sick leave hours 1st day of school term _____
- Residual sick leave hour remaining in bank from preceding year _____
- Total hours in sick leave bank _____

In accordance with the negotiated agreement, Management provides the above mentioned information concerning the total number of sick leave hours to be true and accurate to the best of my knowledge and our records.

_____ _____
Site Administrator Date

Committee Member Signatures: _____ Date _____

_____ Date _____

_____ Date _____

NOTICE: This form must be completed by the site administrator, signed and dated by the appropriate parties, and forwarded to OIEP, Central Office within 30 days from the 1st day of the school term. A copy must also be provided the Committee within the same time period.

## COMMITTEE CERTIFICATION

Site Name: _____

Total Bargaining Unit Contract Educator Employees Sick Leave Hours Donated 1st Pay Period

_____

October 19_____ May 19_____

. Total number of management sick leave seed hours donated 1st day of the school term 19____.

_____ hours

. Residual sick leave hours remaining in sick leave bank as of the beginning of the 1st pay period.

_____ hours

. Total sick leave hours in the sick leave bank.

_____ hours

NOTE: By May 31, this Committee report must be submitted to appropriate line office.

We, the Committee, certify that the above accurately represents the Committee's current records on the sick leave bank.

Committee Member Signatures: _____ Date: _____

_____ Date: _____

_____ Date: _____

COMMITTEE

SICK LEAVE BANK BI-WEEKLY LOG

LOG FOR PERIOD _____ TO _____

. Total sick leave available at beginning of period _____

. Total hours of sick leave approved _____

. Total sick leave remaining _____

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. Current active number of recipients at beginning period _____

. New applicants approved this period _____

. Recipients found ineligible this period _____

. Recipients at end of period _____

# APPLICATION REQUEST FOR RECIPIENT UNDER THE SICK LEAVE BANK PROGRAM

TO BE COMPLETED BY APPLICANT

| 1. Application's Name (Last, First, Middle) | 2. Social Security Number | 3. Date of Birth |
|---|---|---|
| | | |

| 4. Position Title, Pay Plan, and Grade/Pay Level | 5. Are you a OIEP Contract Educator? YES ☐ NO ☐ | 6. Work Telephone Number |
|---|---|---|
| | | |

| 7. Name of Organization (Agency, Department, Office, Division, Branch, etc.) | 8. Payroll Office Number |
|---|---|
| | |

| 9. Are you affected by Medical Emergency? YES ☐ NO ☐ | 10. Date Medical Emergency Began | 11. Date Medical Emergency Ended or is Expected to End |
|---|---|---|
| | | |

12. Nature and Severity of the Medical Emergency

13. Name of Physician Who Will Verify the Medical Emergency [Attach documentation from the physician (or other appropriate expert) showing the diagnosis, prognosis, and duration of the illness].

| 14. What is the Applicants Leave Balance of End of Last Pay Period? | 15. How Many Hours of Leave Without Pay Have Been Used for This Medical Emergency? |
|---|---|
| | |

| 16. Name of Individual Completing the Application (If Applying on Behalf of the Applicant. | Relationship to Applicant | Telephone Number |
|---|---|---|
| | | |

| 17. Signature of Applicant or Individual Applying on Behalf of Applicant (I certify that the Above Statements are True) | Date Signed |
|---|---|
| | |

PRIVACY ACT STATEMENT: Participation in this program is voluntary. The information furnished will be used to identify records properly associated with the application to become a leave recipient. It may also be disclosed to a national, State, or local law enforcement agency where there is an indication of a violation or potential violation of civil or criminal law, rule, or regulation; or to another agency or court where the Government is party to a suit. Executive Order 9397 (November 22, 1943) authorizes use of the Social Security Number (SSN). Furnishing the Social Security Number, as well as other data, is voluntary, but failure to do so may delay or prevent action on the application.

COMMITTEE USE ONLY

Approved ☐ Denied ☐

| Date Received: |
|---|
| Date of Action: |
| Notification Referred: |
| Total Number of Hours Approved: |

Reason for Denial: _____

Committee Member Signatures: _____ Date: _____

_____ Date: _____

_____ Date: _____

TIMEKEEPER USE ONLY (FOLLOW-UP)

Sick Leave Used:

| Date | Pay Period | Used | Balance |
|---|---|---|---|
| | | | |

Sick Leave Returned:

| Date | Balance | Reason |
|---|---|---|
| | | |

# APPLICATION REQUEST TO DONATE SICK LEAVE TO THE SICK LEAVE BANK PROGRAM

I request that sick leave be transferred to the sick leave bank. As of the date indicated below, I have enough leave in my account to cover this amount. The amount of leave I am transferring also is not more than half the hours I will earn this year 120 hours.

I understand that my decision to transfer leave is not revocable.

I have not been directly or indirectly intimidated, threatened or coerced, or promised any benefit by any employee for the purpose of donating or using leave.

PRIVACY ACT STATEMENT: This program is voluntary. The information furnished will be used to identify records properly associated with the leave donation. It may also be disclosed to a national, State, or local law enforcement agency where there is an indication of a violation or potential violation of civil or criminal law, rule, regulation; or to another agency or court when the Government is party to a suit. Executive Order 9397 (November 22, 1943) authorizes use of the Social Security Number (SSN). Furnishing the Social Security Number, as well as other data, is voluntary, but failure to do so may delay or prevent action on the request to donate leave.

TO BE COMPLETED BY LEAVE DONOR

| 1. Name (Last, First, Middle) | 2. Social Security Number | 3. Date of Birth |
|---|---|---|
| | | |
| 4. Position Title, Pay Plan, and Grade/Pay Level | 5. Are you a OIEP Contract Educator? YES ☐ NO ☐ | 6. Work Telephone Number |
| | | |
| 7. Name of Organization (Agency, Department, Office, Division, Branch, etc.) | | |
| | | |
| 8. Amount of Sick leave as of End of Last Pay Period | 9. Amount of Sick Leave To Be Transferred to the Sick Leave Bank | |
| | | |
| 10. Site of Sick Leave Bank Where Leave is Being Donated | | |
| | | |
| 11. Signature (I Certify that I have Read and Understand the Above Statements to be True) | | Date Signed |
| | | |

COMMITTEE USE ONLY

APPROVED ☐ DATE: _____

DENIED ☐ DATE: _____

| |
|---|
| Date Received: |
| Notification Referred: |
| Total # of Hours Transferred: |

Reason for Denial: _____

Committee Member Signatures: _____ Date: _____

_____ Date: _____

_____ Date: _____

L. COMMITTEE CERTIFICATION:

Before any sick leave from the sick leave bank may be approved for any employees for the months proceeding the donation periods of October and May, the Committee must file the respective committee certification form with the Agency's OIEP line office. The Committee certifies that the figures accurately reflect the Committee's records for the sick leave bank. The education line office shall maintain a record of each site's annual sick leave bank balance. These records will be maintained in three year increments.

M. ACCRUAL OF SICK LEAVE:

Sick leave shall accrue to the credit of a sick leave recipient using sick leave withdrawn from a sick leave bank at the same rate as if the employee were then in a paid sick leave status.

The maximum amount of sick leave that may be accrued by a sick leave recipient while using sick leave withdrawn from a sick leave bank in connection with any particular injury or illness may not exceed 40 hours (or, in the case of a part-time employee or an employee with an uncommon tour of duty, the average number of hours of work in the employee's weekly scheduled tour of duty).

If the sick leave recipient's injury or Illness terminates, no sick leave shall be credited to the employee under this section.

N. NOTIFICATION:

Management will inform bargaining unit contract education employees on a one time basis that the sick leave bank is in existence. In this communication management will inform the employees that if they are separated from service, they may donate unused sick leave to the leave bank and time limitations will not be limited to the October and May donation window periods.

In addition, the initial October window period for donating sick leave to the sick leave bank will extend 30 days after the employee receives written notice that the sick leave bank is in existence.

The sick leave bank committee will be in place within 10 days from the date the sites received notification of the sick leave bank existence.

# SAMPLE

Memorandum

To: All Bargaining Unit Contract Education Employees

From: (Agency Superintendent for Education or Area Personnel Officer)

Subject: Notification of NFFE Contract Education Employees Sick Leave Bank Program Existence

In accordance with Section (N), NOTIFICATION, of the negotiated supplemental agreement of the Implementation Procedures for the Sick Leave Bank Program, this is notice that the sick leave bank is in existence. Employees who will separate from service and who will otherwise forfeit their sick leave may donate unused sick leave to the leave bank and time limits will not be limited to the October and May donation window period.

For start up purposes only, the initial window period for donating sick leave to the sick leave bank will extend 30 days from the date the employee receives this notice.

The above mentioned section provides that the sick leave bank committee will be in place within 10 days from the date the sites receive notification of the sick leave bank existence.

The NFFE Union will make a written request to start a sick leave bank at each designated site to the area administrative office and submit the name of the Union's appointed representative.

For information on implementation procedures and applications, please contact the Agency Superintendent for Education or the Area Personnel Officer.

APPROVAL OF SUPPLEMENTAL AGREEMENT FOR SICK LEAVE BANK

MANAGEMENT REPRESENTATIVES

Joseph Jarrett
Navajo Area Personnel Officer

Larry Holman, Navajo Area Agency
Superintendent for Education

Richard L. Garcia
Richard Garcia, Albuquerque
Area Labor Relations Specialist

Don Jones
Don Jones, Navajo Area
Labor Relations specialist

Eileen F. Johnson
Eileen Johnson
Phoenix Area Representative

Robert Andres
Labor Relations Specialist

UNION REPRESENTATIVES:

Ed Buck
Ed Buck, Vice President
NFFE/BIA Council, Aberdeen Area

Christine Plantz
Christine Plantz, Secretary/Treasure
NFFE BIA Council

Patrick Melendy
Patrick Melendy, Vice President
NFFE/BIA Coubncil, Portland Area

CONCURRED:

John G. Combs
John G. Combs
Labor Relations Officer

Edward F. Parisian
Director, Office of Indian Education
Programs (OIEP)

Robert S. Keener
Robert Keener, President
NFFE/BIA Council
30 Aug 91

APPROVED BY:

Morris Simms, Director of Personnel

OCT 24 1991

# EMPLOYEE RIGHTS AND RESPONSIBILITIES
## UNDER THE FAMILY AND MEDICAL LEAVE ACT

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

- For incapacity due to pregnancy, prenatal medical care or child birth;
- To care for the employee's child after birth, or placement for adoption or foster care;
- To care for the employee's spouse, son or daughter, or parent, who has a serious health condition; 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 chronic condition. Other conditions may meet the definition of continuing treatment.

### 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 any proceeding under or relating to FMLA.

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

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

**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.**

**U.S. Department of Labor**
Wage and Hour Division

U.S. Wage and Hour Division
(Revised February 2010)

# Fact Sheet #28: The Family and Medical Leave Act of 1993

See The CFR

**Notice:** On October 28, 2009, the President signed the National Defense Authorization Act for Fiscal Year 2010 (2010 NDAA), Public Law 111-84. Section 565 of the 2010 NDAA amends the military family leave entitlements of the Family and Medical Leave Act (FMLA). These amendments expand coverage for "qualifying exigency" leave to eligible employees with covered family members in the Regular Armed Forces and coverage for "military caregiver leave" to eligible employees who are the spouse, son, daughter, parent, or next of kin of certain veterans with a "serious injury or illness". On December 21, 2009, the President signed the Airline Flight Crew Technical Corrections Act, Public Law 111-119, which modifies the FMLA eligibility requirements for flight crew members. This Fact Sheet does not incorporate these amendments to the FMLA.

The U.S. Department of Labor's Employment Standards Administration, Wage and Hour Division, administers and enforces the Family and Medical Leave Act (FMLA) for all private, state and local government employees, and some federal employees. Most federal and certain congressional employees are also covered by the law and are subject to the jurisdiction of the U.S. Office of Personnel Management or the Congress.

The FMLA entitles eligible employees to take up to 12 workweeks of unpaid, job-protected leave in a 12-month period for specified family and medical reasons, or for any "qualifying exigency" arising out of the fact that a covered military member is on active duty, or has been notified of an impending call or order to active duty, in support of a contingency operation. The FMLA also allows eligible employees to take up to 26 workweeks of job-protected leave in a "single 12-month period" to care for a covered servicemember with a serious injury or illness. *See* Fact Sheet #28A: The Family and Medical Leave Act Military Family Leave Entitlements.

## EMPLOYER COVERAGE

The FMLA applies to all public agencies, including state, local and federal employers, local education agencies (schools), **and** private-sector employers who employed 50 or more employees in 20 or more workweeks in the current or preceding calendar year, including joint employers and successors of covered employers.

## EMPLOYEE ELIGIBILITY

To be eligible for FMLA benefits, an employee **must**:

- work for a covered employer;
- have worked for the employer for a total of 12 months;
- have worked at least 1,250 hours over the previous 12 months; and
- work at a location in the United States or in any territory or possession of the United States where at least 50 employees are employed by the employer within 75 miles.

While the 12 months of employment need not be consecutive, employment periods prior to a break in service of **seven** years or more need not be counted unless the break is occasioned by the employee's fulfillment of his or her National Guard or Reserve military obligation (as protected under the Uniformed Services Employment and Reemployment Rights Act (USERRA)), or a written agreement, including a collective bargaining agreement, exists concerning the employer's intention to rehire the employee after the break in service. *See* "FMLA Special Rules for Returning Reservists."

**LEAVE ENTITLEMENT**

A covered employer must grant an eligible employee up to a total of **12 workweeks** of **unpaid** leave during any 12-month period for one or more of the following reasons:

- for the birth and care of a newborn child of the employee;
- for placement with the employee of a son or daughter for adoption or foster care;
- to care for a spouse, son, daughter, or parent with a serious health condition;
- to take medical leave when the employee is unable to work because of a serious health condition; **or**
- for qualifying exigencies arising out of the fact that the employee's spouse, son, daughter, or parent is on active duty or call to active duty status as a member of the National Guard or Reserves in support of a contingency operation.

A covered employer also must grant an eligible employee who is a spouse, son, daughter, parent, or next of kin of a current member of the Armed Forces, including a member of the National Guard or Reserves, with a serious injury or illness up to a total of **26 workweeks** of **unpaid** leave during a "single 12-month period" to care for the servicemember. For specific information regarding military family leave, *see* "Fact Sheet #28A: The Family and Medical Leave Act Military Family Leave Entitlements."

Spouses employed by the same employer are limited in the **amount of** family leave they may take for the birth and care of a newborn child, placement of a child for adoption or foster care, or to care for a parent who has a serious health condition to a combined total of 12 workweeks (or 26 workweeks if leave to care for a covered servicemember with a serious injury or illness is also used). Leave for birth and care, or placement for adoption or foster care, must conclude within 12 months of the birth or placement.

Under some circumstances, employees may take FMLA leave intermittently – taking leave in separate blocks of time for a single qualifying reason – or on a reduced leave schedule – reducing the employee's usual weekly or daily work schedule. When leave is needed for planned medical treatment, the employee must make a reasonable effort to schedule treatment so as not to unduly disrupt the employer's operation. If FMLA leave is for birth and care, or placement for adoption or foster care, use of intermittent leave is subject to the employer's approval.

Under certain conditions, employees **or** employers may choose to "substitute" (run concurrently) accrued **paid** leave (such as sick or vacation leave) to cover some or all of the FMLA leave. An employee's ability to substitute accrued paid leave is determined by the terms and conditions of the employer's normal leave policy.

"**Serious health condition**" means an illness, injury, impairment, or physical or mental condition that involves either:

- Inpatient care (*i.e.*, an overnight stay) in a hospital, hospice, or residential medical-care facility, including any period of incapacity (*i.e.*, inability to work, attend school, or perform other regular daily activities) or subsequent treatment in connection with such inpatient care; **or**

- Continuing treatment by a health care provider, which includes:

  (1) A period of incapacity lasting more than three consecutive, full calendar days, and any subsequent treatment or period of incapacity relating to the same condition that **also** includes:
  - treatment two or more times by or under the supervision of a health care provider (*i.e.*, in-person visits, the first within 7 days and both within 30 days of the first day of incapacity); **or**

- one treatment by a health care provider (*i.e.*, an in-person visit within 7 days of the first day of incapacity) with a continuing regimen of treatment (*e.g.*, prescription medication, physical therapy); **or**

(2) Any period of incapacity related to pregnancy or for prenatal care. A visit to the health care provider is not necessary for each absence; **or**

(3) Any period of incapacity or treatment for a chronic serious health condition which continues over an extended period of time, requires periodic visits (at least twice a year) to a health care provider, and may involve occasional episodes of incapacity. A visit to a health care provider is not necessary for each absence; **or**

(4) A period of incapacity that is permanent or long-term due to a condition for which treatment may not be effective. Only supervision by a health care provider is required, rather than active treatment; **or**

(5) Any absences to receive multiple treatments for restorative surgery or for a condition that would likely result in a period of incapacity of more than three days if not treated.

## MAINTENANCE OF HEALTH BENEFITS

A covered employer is required to maintain group health insurance coverage for an employee on FMLA leave whenever such insurance was provided before the leave was taken and on the same terms as if the employee had continued to work. If applicable, arrangements will need to be made for employees to pay their share of health insurance premiums while on leave. In some instances, the employer may recover premiums it paid to maintain health coverage for an employee who fails to return to work from FMLA leave.

## JOB RESTORATION

Upon return from FMLA leave, an employee must be restored to the employee's original job, or to an equivalent job with equivalent pay, benefits, and other terms and conditions of employment. An employee's use of FMLA leave cannot result in the loss of any employment benefit that the employee earned or was entitled to **before** using FMLA leave, nor be counted against the employee under a "no fault" attendance policy. If a bonus or other payment, however, is based on the achievement of a specified goal such as hours worked, products sold, or perfect attendance, and the employee has not met the goal due to FMLA leave, payment may be denied unless it is paid to an employee on equivalent leave status for a reason that does not qualify as FMLA leave.

An employee has no greater right to restoration or to other benefits and conditions of employment than if the employee had been continuously employed.

## NOTICE AND CERTIFICATION

<u>Employee Notice</u>
Employees seeking to use FMLA leave are required to provide 30-day advance notice of the need to take FMLA leave when the need is foreseeable and such notice is practicable. If leave is foreseeable less than 30 days in advance, the employee must provide notice as soon as practicable – generally, either the same or next business day. When the need for leave is not foreseeable, the employee must provide notice to the employer as soon as practicable under the facts and circumstances of the particular case. Absent unusual circumstances, employees must comply with the employer's usual and customary notice and procedural requirements for requesting leave.

Employees must provide sufficient information for an employer reasonably to determine whether the FMLA may apply to the leave request. Depending on the situation, such information may include that the employee is incapacitated due to pregnancy, has been hospitalized overnight, is unable to perform the functions of the job, and/or that the employee or employee's qualifying family member is under the continuing care of a health care provider.

When an employee seeks leave for a FMLA-qualifying reason for the **first** time, the employee need not expressly assert FMLA rights or even mention the FMLA. When an employee seeks leave, however, due to a FMLA-qualifying reason for which the employer has previously provided the employee FMLA-protected leave, the employee **must** specifically reference either the qualifying reason for leave or the need for FMLA leave.

Employer Notice

Covered employers must post a notice approved by the Secretary of Labor explaining rights and responsibilities under the FMLA. An employer that willfully violates this posting requirement may be subject to a civil money penalty of up to $110 for each separate offense. Additionally, employers must either include this general notice in employee handbooks or other written guidance to employees concerning benefits, or must distribute a copy of the notice to each new employee upon hiring. Employers may use the notice prepared by U.S. Department of Labor to meet this requirement.

When an employee requests FMLA leave or the employer acquires knowledge that leave may be for a FMLA purpose, the employer must notify the employee of his or her eligibility to take leave, and inform the employee of his/her rights and responsibilities under the FMLA. When the employer has enough information to determine that leave is being taken for a FMLA-qualifying reason, the employer must notify the employee that the leave is designated and will be counted as FMLA leave. Employers may use the optional forms WH-381 and WH-382 prepared by the U.S. Department of Labor to meet these notification requirements.

Certification

Employers may require that an employee's request for leave due to a serious health condition affecting the employee or a covered family member be supported by a certification from a health care provider. An employer may require second or third medical opinions (at the employer's expense) and periodic recertification of a serious health condition. An employer may use a health care provider, a human resource professional, a leave administrator, or a management official – but not the employee's direct supervisor – to authenticate or clarify a medical certification of a serious health condition. An employer may have a uniformly-applied policy requiring employees returning from leave for their own serious health condition to submit a certification that they are able to resume work. If reasonable safety concerns exist, an employer may, under certain circumstances, require such a certification for employees returning from intermittent FMLA leave. Employers may use the optional forms WH-380-E and WH-380-F prepared by the U.S. Department of Labor for obtaining medical certifications of serious health conditions.

## UNLAWFUL ACTS

It is unlawful for any employer to interfere with, restrain, or deny the exercise of any right provided by the FMLA. It is also unlawful for an employer to discharge or discriminate against any individual for opposing any practice, or because of involvement in any proceeding, related to the FMLA.

## ENFORCEMENT

The Wage and Hour Division investigates complaints. If violations cannot be satisfactorily resolved, the U.S. Department of Labor may bring action in court to compel compliance. Individuals may also be able to bring a private civil action against an employer for violations.

**OTHER PROVISIONS**

Special rules apply to employees of local education agencies. Generally, these rules apply to intermittent leave or when leave is required near the end of a school term.

Salaried executive, administrative, and professional employees of covered employers who meet the Fair Labor Standards Act (FLSA) criteria for exemption from minimum wage and overtime under Regulations, 29 CFR Part 541, do not lose their FLSA-exempt status by using any unpaid FMLA leave. This special exception to the "salary basis" requirements for FLSA's exemption extends only to an "eligible" employee's use of leave required by the FMLA.

**For additional information, visit our Wage and Hour Division Website: http://www.wagehour.dol.gov and/or call our toll-free information and helpline, available 8 a.m. to 5 p.m. in your time zone, 1-866-4-USWAGE (1-866-487-9243).**

This publication is for general information and is not to be considered in the same light as official statements of position contained in the regulations.

**U.S. Department of Labor**
Frances Perkins Building
200 Constitution Avenue, NW
Washington, DC 20210

**1-866-4-USWAGE**
TTY: 1-866-487-9243
**Contact Us**

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

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

U.S. Wage and Hour Division

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

**SECTION I: For Completion by the EMPLOYER**

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

Employer name and contact: _____

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

Employee's essential job functions: _____

_____

Check if job description is attached: .

**SECTION II: For Completion by the EMPLOYEE**

**INSTRUCTIONS to the EMPLOYEE:** Please complete Section II before giving this form to your medical provider. The FMLA permits an employer to require that you submit a timely, complete, and sufficient medical certification to support a request for FMLA leave due to your own serious health condition. If requested by your employer, your response is required to obtain or retain the benefit of FMLA protections. 29 U.S.C. §§ 2613, 2614(c)(3). Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA request. 20 C.F.R. § 825.313. Your employer must give you at least 15 calendar days to return this form. 29 C.F.R. § 825.305(b).

Your name: _____
First Middle Last

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

**INSTRUCTIONS to the HEALTH CARE PROVIDER:** Your patient has requested leave under the FMLA. Answer, fully and completely, all applicable parts. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can; terms such as "lifetime," "unknown," or "indeterminate" may not be sufficient to determine FMLA coverage. Limit your responses to the condition for which the employee is seeking leave. Please be sure to sign the form on the last page.

Provider's name and business address: _____

Type of practice / Medical specialty: _____

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


CONTINUED ON NEXT PAGE

PART A: MEDICAL FACTS

1. Approximate date condition commenced: _____

   Probable duration of condition: _____

   **Mark below as applicable:**
   Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility?
   No ___Yes. If so, dates of admission:

   _____

   Date(s) you treated the patient for condition:

   _____

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

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

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

   _____

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

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

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

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

   _____

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

   _____

   _____

   _____

   _____

   _____

   _____

   _____

PART B: AMOUNT OF LEAVE NEEDED

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

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

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

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

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

   _____

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

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

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

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

   _____

   _____

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

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

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

ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER.

_____

_____

_____

_____

_____

_____

**Signature of Health Care Provider** **Date**

**PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT**

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

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

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


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

**SECTION I: For Completion by the EMPLOYER**

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

Employer name and contact: _____

_____

**SECTION II: For Completion by the EMPLOYEE**

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

Your name: _____
First Middle Last

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

Relationship of family member to you: _____

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

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

_____

_____

_____

_____ _____
Employee Signature Date


CONTINUED ON NEXT PAGE

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

**INSTRUCTIONS to the HEALTH CARE PROVIDER:** The employee listed above has requested leave under the FMLA to care for your patient. Answer, fully and completely, all applicable parts below. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can; terms such as "lifetime," "unknown," or "indeterminate" may not be sufficient to determine FMLA coverage. Limit your responses to the condition for which the patient needs leave. Page 3 provides space for additional information, should you need it. Please be sure to sign the form on the last page.

Provider's name and business address:_____

Type of practice / Medical specialty: _____

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

PART A: MEDICAL FACTS

1. Approximate date condition commenced: _____

   Probable duration of condition: _____

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

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

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

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

   Was the patient referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)?
   ____ No ____Yes. If so, state the nature of such treatments and expected duration of treatment:

   _____

   _____

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

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

_____

_____

_____

_____

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

4. Will the patient be incapacitated for a single continuous period of time, including any time for treatment and recovery? ___No ___Yes.

   Estimate the beginning and ending dates for the period of incapacity: _____

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

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

   _____

   _____

   _____

   _____

   _____

5. Will the patient require follow-up treatments, including any time for recovery? ___No ___Yes.

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

   _____

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

   _____

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

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

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

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

   _____

   _____

   _____

   _____

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

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

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

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

   Does the patient need care during these flare-ups? ____ No . Yes.

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

   _____

   _____

   _____

   _____

ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER.

_____

_____

_____

_____

_____

_____

_____ _____

**Signature of Health Care Provider** **Date**

**PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT**

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

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

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


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

**Notice to the EMPLOYER INSTRUCTIONS to the EMPLOYER:** The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA leave due to a serious injury or illness of a covered servicemember to submit a certification providing sufficient facts to support the request for leave. Your response is voluntary. While you are not required to use this form, you may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. § 825.310. Employers must generally maintain records and documents relating to medical certifications, recertifications, or medical histories of employees or employees' family members, created for FMLA purposes as confidential medical records in separate files/records from the usual personnel files and in accordance with 29 C.F.R. § 1630.14(c)(1), if the Americans with Disabilities Act applies.

**SECTION I: For Completion by the EMPLOYEE and/or the COVERED SERVICEMEMBER for whom the Employee Is Requesting Leave INSTRUCTIONS to the EMPLOYEE or COVERED SERVICEMEMBER:** Please complete Section I before having Section II completed. The FMLA permits an employer to require that an employee submit a timely, complete, and sufficient certification to support a request for FMLA leave due to a serious injury or illness of a covered servicemember. If requested by the employer, your response is required to obtain or retain the benefit of FMLA-protected leave. 29 U.S.C. §§ 2613, 2614(c)(3). Failure to do so may result in a denial of an employee's FMLA request. 29 C.F.R. § 825.310(f). The employer must give an employee at least 15 calendar days to return this form to the employer.

**SECTION II: For Completion by a UNITED STATES DEPARTMENT OF DEFENSE ("DOD") HEALTH CARE PROVIDER or a HEALTH CARE PROVIDER who is either: (1) a United States Department of Veterans Affairs ("VA") health care provider; (2) a DOD TRICARE network authorized private health care provider; or (3) a DOD non-network TRICARE authorized private health care provider INSTRUCTIONS to the HEALTH CARE PROVIDER:** The employee listed on Page 2 has requested leave under the FMLA to care for a family member who is a member of the Regular Armed Forces, the National Guard, or the Reserves who is undergoing medical treatment, recuperation, or therapy, is otherwise in outpatient status, or is otherwise on the temporary disability retired list for a serious injury or illness. For purposes of FMLA leave, a serious injury or illness is one that was incurred in the line of duty on active duty that may render the servicemember medically unfit to perform the duties of his or her office, grade, rank, or rating.

A complete and sufficient certification to support a request for FMLA leave due to a covered servicemember's serious injury or illness includes written documentation confirming that the covered servicemember's injury or illness was incurred in the line of duty on active duty and that the covered servicemember is undergoing treatment for such injury or illness by a health care provider listed above. Answer, fully and completely, all applicable parts. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can; terms such as "lifetime," "unknown," or "indeterminate" may not be sufficient to determine FMLA coverage. Limit your responses to the condition for which the employee is seeking leave.

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

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

U.S. Wage and Hour Division

**SECTION I: For Completion by the EMPLOYEE and/or the COVERED SERVICEMEMBER for whom the Employee Is Requesting Leave:** (This section must be completed first before any of the below sections can be completed by a health care provider.)

Part A: EMPLOYEE INFORMATION

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

_____

Name of Employee Requesting Leave to Care for Covered Servicemember:

_____
First Middle Last

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

_____
First Middle Last

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

Part B: COVERED SERVICEMEMBER INFORMATION

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

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

_____

Is the covered servicemember assigned to a military medical treatment facility as an outpatient or to a unit established for the purpose of providing command and control of members of the Armed Forces receiving medical care as outpatients (such as a medical hold or warrior transition unit)? ☐ Yes ☐ No If yes, please provide the name of the medical treatment facility or unit:

_____

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

Part C: CARE TO BE PROVIDED TO THE COVERED SERVICEMEMBER

Describe the Care to Be Provided to the Covered Servicemember and an Estimate of the Leave Needed to Provide the Care:

_____

**SECTION II: For Completion by a United States Department of Defense ("DOD") Health Care Provider or a Health Care Provider who is either: (1) a United States Department of Veterans Affairs ("VA") health care provider; (2) a DOD TRICARE network authorized private health care provider; or (3) a DOD non-network TRICARE authorized private health care provider. If you are unable to make certain of the military-related determinations contained below in Part B, you are permitted to rely upon determinations from an authorized DOD representative (such as a DOD recovery care coordinator).** (Please ensure that Section I above has been completed before completing this section.) Please be sure to sign the form on the last page.

Part A: HEALTH CARE PROVIDER INFORMATION

Health Care Provider's Name and Business Address:

_____

Type of Practice/Medical Specialty: _____

Please state whether you are either: (1) a DOD health care provider; (2) a VA health care provider; (3) a DOD TRICARE network authorized private health care provider; or (4) a DOD non-network TRICARE authorized private health care provider: _____

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

PART B: MEDICAL STATUS

(1) Covered Servicemember's medical condition is classified as (Check One of the Appropriate Boxes):

☐ **(VSI) Very Seriously Ill/Injured** – Illness/Injury is of such a severity that life is imminently endangered. Family members are requested at bedside immediately. (Please note this is an internal DOD casualty assistance designation used by DOD healthcare providers.)

☐ **(SI) Seriously Ill/Injured** – Illness/injury is of such severity that there is cause for immediate concern, but there is no imminent danger to life. Family members are requested at bedside. (Please note this is an internal DOD casualty assistance designation used by DOD healthcare providers.)

☐ **OTHER Ill/Injured** – a serious injury or illness that may render the servicemember medically unfit to perform the duties of the member's office, grade, rank, or rating.

☐ **NONE OF THE ABOVE** (Note to Employee: If this box is checked, you may still be eligible to take leave to care for a covered family member with a "serious health condition" under § 825.113 of the FMLA. If such leave is requested, you may be required to complete DOL FORM WH-380 or an employer-provided form seeking the same information.)

(2) Was the condition for which the Covered Service member is being treated incurred in line of duty on active duty in the armed forces? ☐ Yes ☐ No

(3) Approximate date condition commenced: _____

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

(5) Is the covered servicemember undergoing medical treatment, recuperation, or therapy? ☐ Yes ☐ No. If yes, please describe medical treatment, recuperation or therapy:

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

(1) Will the covered servicemember need care for a single continuous period of time, including any time for treatment and recovery? ☐ Yes ☐ No
If yes, estimate the beginning and ending dates for this period of time: _____

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

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

(4) Is there a medical necessity for the covered servicemember to have periodic care for other than scheduled follow-up treatment appointments (e.g., episodic flare-ups of medical condition)? ☐ Yes ☐ No If yes, please estimate the frequency and duration of the periodic care:

_____

_____

**Signature of Health Care Provider: _____ Date: _____**

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

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


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

## SECTION I: For Completion by the EMPLOYER

**INSTRUCTIONS to the EMPLOYER:** The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA leave due to a qualifying exigency to submit a certification. Please complete Section I before giving this form to your employee. Your response is voluntary, and while you are not required to use this form, you may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. § 825.309.

Employer name: _____

Contact Information: _____

## SECTION II: For Completion by the EMPLOYEE

**INSTRUCTIONS to the EMPLOYEE:** Please complete Section II fully and completely. The FMLA permits an employer to require that you submit a timely, complete, and sufficient certification to support a request for FMLA leave due to a qualifying exigency. Several questions in this section seek a response as to the frequency or duration of the qualifying exigency. Be as specific as you can; terms such as "unknown," or "indeterminate" may not be sufficient to determine FMLA coverage. Your response is required to obtain a benefit. 29 C.F.R. § 825.310. While you are not required to provide this information, failure to do so may result in a denial of your request for FMLA leave. Your employer must give you at least 15 calendar days to return this form to your employer.

Your Name: _____
First Middle Last

Name of covered military member on active duty or call to active duty status in support of a contingency operation:

_____
First Middle Last

Relationship of covered military member to you: _____

Period of covered military member's active duty: _____

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

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


CONTINUED ON NEXT PAGE

## PART A: QUALIFYING REASON FOR LEAVE

1. Describe the reason you are requesting FMLA leave due to a qualifying exigency (including the specific reason you are requesting leave):

_____

_____

_____

_____

_____

_____

2. A complete and sufficient certification to support a request for FMLA leave due to a qualifying exigency includes any available written documentation which supports the need for leave; such documentation may include a copy of a meeting announcement for informational briefings sponsored by the military, a document confirming an appointment with a counselor or school official, or a copy of a bill for services for the handling of legal or financial affairs. Available written documentation supporting this request for leave is attached. ☐ Yes ☐ No ☐ None Available

## PART B: AMOUNT OF LEAVE NEEDED

1. Approximate date exigency commenced: _____

   Probable duration of exigency: _____

2. Will you need to be absent from work for a single continuous period of time due to the qualifying exigency? ☐ No ☐ Yes.

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

   _____.

3. Will you need to be absent from work periodically to address this qualifying exigency? ☐ No ☐ Yes.

   Estimate schedule of leave, including the dates of any scheduled meetings or appointments:_____

   _____

   _____

   _____

   Estimate the frequency and duration of each appointment, meeting, or leave event, including any travel time (i.e., 1 deployment-related meeting every month lasting 4 hours):

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

   Duration: _____ hours ___ day(s) per event.


CONTINUED ON NEXT PAGE

PART C:

If leave is requested to meet with a third party (such as to arrange for childcare, to attend counseling, to attend meetings with school or childcare providers, to make financial or legal arrangements, to act as the covered military member's representative before a federal, state, or local agency for purposes of obtaining, arranging or appealing military service benefits, or to attend any event sponsored by the military or military service organizations), a complete and sufficient certification includes the name, address, and appropriate contact information of the individual or entity with whom you are meeting (i.e., either the telephone or fax number or email address of the individual or entity). This information may be used by your employer to verify that the information contained on this form is accurate.

Name of Individual: _____ Title: _____

Organization: _____

Address: _____

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

Email: _____

Describe nature of meeting: _____

_____

_____

_____

_____

_____

_____

_____

_____

PART D:

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

_____ _____

Signature of Employee Date

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BUREAU OF INDIAN EDUCATION
Reduction-In-Force OUTPLACEMENT ASSISTANCE REQUEST FORM

Employee Name: _____

Place of Employment (School/Duty Location): _____

Title/grade: _____

Date received Reduction-In-Force Notice: _____

## Section I - Identification

INSTRUCTIONS: This form is to be completed by Contract Education Personnel, CE or CY ONLY, and submitted to the BIE Human Resources Office, P.O. BOX 769, ALBUQUERQUE, NEW MEXICO, 87103, within 60 days of receipt of RIF separation notice along with the following:

_____ Updated OF-612, Optional Application for Federal Employment, or Resume.

_____ Official Transcripts, if applicable

_____ Copy of state certification and/or license if required

_____ Copy of Specific Notice of Reduction-in-force

__X__ Copy of SF-50B, RIF Separation action (Will be provided by HR Specialist, if applicable)

## Section II – Job availability

Please indicate below the types of positions, series, and pay levels for which you are qualified and will accept referrals. Also include your geographic preference for employment within the BIE personnel system (list below).

1. _____
   Job title, series and pay level

2. _____
   Job title, series and pay level

**Please indicate if you are available for: _____Full Time _____Part Time**

Geographic preference for employment

1. _____
Education Line Office and/or School duty location

2. _____
Education Line Office and/or School duty location

3. _____
Education Line Office and/or School duty location

**Employee:**

**I certify, I am available for the positions, series, and pay level of employment and duty locations I have selected above. I further understand that any or all of the information contained herein will be made available to prospective employers listed above within the Bureau of Indian Education. I understand that if I fail to permit release of this information, I will not be given further consideration for this outplacement program. I also understand that placement requires local school board consultation.**

_____ _____
**Employee Signature** **Date**

**Bureau of Indian Education Human Resources Office:**

**I certify the information supplied as to the employee's current last appointment is correct. The employee's current status is:**

**Separated by RIF - effective date:** _____

**Under Specific Notice of Separation by RIF to be effective:** _____

**Date the employee's above credentials referred to the specified Education Line**

**Office and/or School Duty Location:** _____

_____ _____
**Human Resources Officer/Specialist** **Date**

**NOTE: It is the responsibility of the hiring official (Line office or School level) to make direct contact with the employee and follow their selection process.**

# Department of Interior

Re-Employment Priority List Application Form

(see reverse side for instructions and notice)

## Part I: Applicant Data

| 1. Applicant Name: (Last, first, middle initial) | 2. SSN |
|---|---|
| 3. Address: | 4. Phone No: |

| 5. Date of Separation Notice: | 6. Separation Date: |
|---|---|

| 7A. Retention Order (Circle One in Each Below) | | | | | B. Indian Preference (BIA ONLY): | | | |
|---|---|---|---|---|---|---|---|---|
| Tenure Group: | 1 | 2 | Subgroup: | AD A B | | Yes | | No |

## Part II: Applicant Employment/Availability Data

| 8. Current (LAST) Position (Enter Job Series/Grade/Title below): | | |
|---|---|---|
| Series: | Grade: | Title: |

| 9. Current Duty Station Location (City, State): |
|---|

| 10. Current Appointment Type (Check One) | | 11. Willing to relocate (Optional): | | 12. Lowest Grade that you will accept (not in excess of 3 grades/intervals below current & list no more than 3): | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | Competitive | | Yes | | | | | | |
| | Excepted | | No | A | | B | | C | |

| 13. Current Work Schedule (Check One) | | 14. Other work schedule willing to accept: | | 15. Select one or more Type of Position willing to accept: | |
|---|---|---|---|---|---|
| | Full-time | | Full-time | | |
| | Part-time | | Part-time | | Permanent |
| | Seasonal | | Seasonal | | |
| | Intermittent | | Intermittent | | Temporary |

| 16. Other positions for which you believe that your are qualified (list below): | | |
|---|---|---|
| (A) Series: | Grade: | Title: |
| (A) Series: | Grade: | Title: |
| (A) Series: | Grade: | Title: |

## Part III: Applicant's Signature:

| Signature | Date: |
|---|---|

## Part IV: Entries made by the Applicant's SPO

| 17. Bureau: | 18. Name of SPO Contact: |
|---|---|

| 19. SPO Address w/phone no.: |
|---|

| 20. SPO Verification of Qualifications for Series/Grade/Title listed by Applicant in Field 16: | | |
|---|---|---|
| 16(a) | 16(B) | 16(C) |

## RPL APPLICATION FORM

INTERIM INSTRUCTIONS: This form (reverse side) is to be completed by the applicant with the assistance of the Servicing Personnel Office. Parts I, II, and III are to be completed by the applicant. Part IV, including the certification of qualifications for the job series and grades being entered by the applicant, is to be completed by the Servicing Personnel Office. The SPO will submit one copy to the Reemployment Priority List Coordinator, Joyce Roberts (PPM/MIB), Phone 202-208-6618. If at all possible, submit form by E-mail at – IOS.

ADDITIONAL PART OF RPL REGISTRATION: As an additional part of RPL application, the employee MUST also provide a one-page business resume to be kept on file at the employee's former SPO to assist in responding to RPL information requests from potential DOI employers and selecting officials. (11/2/95)

## NOTICE TO APPLICANTS -- DOI REEMPLOYMENT PRIORITY LIST

The Department of the Interior Reemployment Priority List (RPL) is a program that provides permanent DOI employees who are separated due to RIF first consideration for reemployment in competitive service vacancies for which they are qualified in DOI and its bureaus within the commuting area. The DOI RPL is maintained in accordance with OPM regulations found at 5 CFR 330.

A DOI employee may submit an application for the RPL to their Servicing Personnel Office (SPO) as soon as he/she receives a notice of proposed separation, but must apply no later than 30 days after RIF separation date in order to be included on the RPL. The agency (SPO) has a maximum of 10 days to enter the employee application on the RPL.

The employee's application must include certain specified information such as job series, grade, tenure group and sub-group, duty station/commuting area, etc., and information on other conditions under which the employee will accept re-employment; e.g., different work schedules, availability for temporary or permanent appointment, etc., in order to be considered for the RPL. (Ref. 5 CFR 330.202) SEE THE OTHER SIDE OF THIS DOCUMENT FOR APPLICATION FORM.

Applicants are also notified that in order to be selected for a position, they must be qualified to fill it, and that their qualification for each series for which they are registered is subject to verification by the Servicing Personnel Office. Applicants who have questions concerning types of series and grades for which they are qualified, should seek assistance from their Servicing Personnel Office.

OPM regulations provide specific conditions for maintaining eligibility on the RPL and for being removed from eligibility on the RPL. An explanation of these conditions is available from your Servicing Personnel Office (SPO). All RPL applicants MUST keep their former SPO advised of their current address and telephone number where they may be contacted during their RPL eligibility period, and when they accept or decline an offer of employment. Applicants are notified that consideration for all jobs will be suspended for any individual who cannot be reached by the DOI. Consideration can be reinstated by submission of an updated application to the former SPO, but the original time period of RPL eligibility cannot be extended for any period of suspension.

Privacy Act Notice

Pursuant to requirements of Public Law 93-579, the Privacy Act of 1974, you are advised of the following: the authority for solicitation of this information is sections 1302, 3301, and 3304 of Title 5 of the United States Code; Reorganization Plan 3 of 1950; and Executive Order 10561. The principal purpose of this information is to establish eligibility and provide placement assistance for Interior Department employees who are eligible for the Department of the Interior Reemployment Priority List (RPL) as provided in 5CFR330. Your application form and/or the information you provide for the RPL will be disclosed to personnel offices and supervisors/managers throughout the Department of the Interior. Also, it may be referred to other Federal offices and state and local government agencies that have jobs for which you may be qualified. Disclosure of the information is completely voluntary. The only consequence of not providing this information is self-elimination for placement assistance through the RPL.