SECTION 10
FORMS

ACKNOWLEDGEMENT **SECTION 10.1**

Please sign the attached, and present the acknowledgement slip below to your Appointing Authority for inclusion in your Personnel File.

ACKNOWLEDGEMENT

I have been informed of the existence of a Belmont County Personnel Policy Manual, and have been given an opportunity to review its contents. I have familiarized myself with the information in these directives and understand that I am governed by them. I further understand that this manual is not an employment contract.

Since the information in these directives is subject to change, it is understood that I will be notified of such change through the usual channels of communication. I agree to comply with all changes to the policies and procedures contained in the manual.

_____ _____

Signature of Employee Date

****

PLEASE TYPE OR PRINT RESPONSES TO ALL OF THE QUESTIONS CONTAINED ON THE ENTIRE APPLICATION FORM

****

POSITION SOUGHT:_____

NAME:_____

Last First Middle Initial

HOME ADDRESS:_____

CITY/STATE/ZIP:_____

COUNTY:_____ HOME PHONE:_____

S.S. NUMBER:_____ ARE YOU AN ADULT? YES ☐ NO ☐

****

EMPLOYMENT HISTORY AND WORK EXPERIENCE

IN THIS SECTION, LIST ALL EMPLOYMENT HISTORY AND WORK EXPERIENCE IN DATE ORDER, INCLUDING MILITARY EXPERIENCE. BEGIN WITH YOUR CURRENT EMPLOYER. USE ADDITIONAL PAPER IF NECESSARY. FAILURE TO INCLUDE ALL EMPLOYMENT MAY BE GROUNDS FOR DISQUALIFICATION.

****

CURRENT EMPLOYER:_____

(Enter "None" if unemployed)

MAY WE CONTACT YOUR CURRENT EMPLOYER PRIOR TO EMPLOYMENT?

YES ☐ NO ☐

ADDRESS:_____

PHONE NUMBER:_____

DATES EMPLOYED:_____ TO:_____

JOB TITLE:_____

SUPERVISOR'S NAME:_____

BEGINNING SALARY:_____ PER____ CURRENT SALARY:_____ PER____

DESCRIBE YOUR DUTIES, RESPONSIBILITIES, EQUIPMENT OPERATED, PROMOTIONS, ETC.:_____

_____

_____

WHY DO YOU WANT TO LEAVE?_____

****

PREVIOUS EMPLOYER:_____

ADDRESS:_____

PHONE NUMBER:_____

DATES EMPLOYED:_____ TO:_____

JOB TITLE:_____

SUPERVISOR'S NAME:_____

BEGINNING SALARY:_____ PER____ CURRENT SALARY:_____ PER____

DESCRIBE YOUR DUTIES, RESPONSIBILITIES, EQUIPMENT OPERATED, PROMOTIONS, ETC.:_____

_____

_____

WHY DID YOU LEAVE?_____

****

PREVIOUS EMPLOYER:_____

ADDRESS:_____

PHONE NUMBER:_____

DATES EMPLOYED:_____ TO:_____

JOB TITLE:_____

SUPERVISOR'S NAME:_____
BEGINNING SALARY:_____ PER____ CURRENT SALARY:_____ PER____
DESCRIBE YOUR DUTIES, RESPONSIBILITIES, EQUIPMENT OPERATED, PROMOTIONS, ETC.:_____
_____
_____
WHY DID YOU LEAVE?_____
****
PREVIOUS EMPLOYER:_____
ADDRESS:_____
PHONE NUMBER:_____
DATES EMPLOYED:_____ TO:_____
JOB TITLE:_____
SUPERVISOR'S NAME:_____
BEGINNING SALARY:_____ PER____ CURRENT SALARY:_____ PER____
DESCRIBE YOUR DUTIES, RESPONSIBILITIES, EQUIPMENT OPERATED, PROMOTIONS, ETC.:_____
_____
_____
WHY DID YOU LEAVE?_____
****
PREVIOUS EMPLOYER:_____
ADDRESS:_____
PHONE NUMBER:_____
DATES EMPLOYED:_____ TO:_____
JOB TITLE:_____
SUPERVISOR'S NAME:_____
BEGINNING SALARY:_____ PER____ CURRENT SALARY:_____ PER____
DESCRIBE YOUR DUTIES, RESPONSIBILITIES, EQUIPMENT OPERATED, PROMOTIONS, ETC.:_____
_____
_____
WHY DID YOU LEAVE?_____
****
IF YOU NEED TO LIST ANY ADDITIONAL PREVIOUS EMPLOYERS, PLEASE USE A BLANK SHEET OF PAPER TO DO SO.
****

EDUCATION AND TRAINING

THIS SECTION IS INTENDED TO GIVE THE EMPLOYER INFORMATION ABOUT THE EDUCATION AND TRAINING THAT THE APPLICANT HAS COMPLETED, AND TO DEMONSTRATE THE SKILLS, KNOWLEDGE, AND ABILITIES OF THE APPLICANT TO PERFORM THE JOB DUTIES OF THE POSITION.
****
HIGH SCHOOL ATTENDED:_____
ADDRESS:_____
DID YOU GRADUATE?_____ HIGH SCHOOL EQUIVALENT?_____
COURSES PERTAINING TO JOB APPLIED FOR:_____
_____
ACTIVITIES, AWARDS, SPORTS, ETC.:_____
_____
_____
COLLEGE OR TRADE SCHOOL ATTENDED:_____
ADDRESS:_____
DID YOU GRADUATE?_____ DEGREE:_____
COURSES PERTAINING TO JOB APPLIED FOR:_____

ACTIVITIES, AWARDS, SPORTS, ETC.:_____

GRADUATE SCHOOL(S) ATTENDED:_____

ADDRESS:_____
DID YOU GRADUATE?_____ DEGREE:_____
****

PLEASE USE THE FOLLOWING SPACE TO PROVIDE ANY FURTHER INFORMATION ON TRAINING, EDUCATION, SKILLS, ABILITIES, HOBBIES, VOLUNTEER WORK, ETC., THAT YOU POSSESS OR HAVE EXPERIENCED THAT MAY BE HELPFUL IN THE EVALUATION OF YOUR APPLICATION.
****

****

PERSONAL INFORMATION
****

DO YOU HAVE ANY COMMITMENTS (I.E., SECOND JOB, SCHOOL, ETC.?) WHICH MIGHT INTERFERE WITH, OR ADVERSELY AFFECT, YOUR EMPLOYMENT SHOULD WE SELECT YOU FOR A POSITION? YES ☐ NO ☐
IF YES, PLEASE EXPLAIN:_____

HAVE YOU EVER BEEN CONVICTED OF A FELONY? YES ☐ NO ☐
IF YES, PLEASE EXPLAIN:_____

(THE EMPLOYER WILL ONLY CONSIDER SPECIFIC CRIMES RELATED TO QUALIFICATIONS FOR POSITIONS APPLIED FOR.)
DO YOU POSSESS A VALID DRIVERS LICENSE? YES ☐ NO ☐
IF NO, CAN YOU OBTAIN ONE PRIOR TO EMPLOYMENT? YES ☐ NO ☐
ARE YOU ELIGIBLE TO WORK IN THE UNITED STATES? YES ☐ NO ☐
ARE YOU RELATED TO ANYONE THAT IS CURRENTLY EMPLOYED BY BELMONT COUNTY? YES ☐ NO ☐
PLEASE LIST THREE REFERENCES WHO ARE NOT RELATED TO YOU THAT YOU HAVE KNOWN AT LEAST ONE YEAR:
NAME:_____
PHONE:_____ ADDRESS:_____

NAME:_____
PHONE:_____ ADDRESS:_____

NAME:_____
PHONE:_____ ADDRESS:_____
****

PLEASE READ EACH OF THE FOLLOWING PARAGRAPHS CAREFULLY. INDICATE YOUR UNDERSTANDING OF, AND CONSENT TO, THE CONTENTS AND CONDITIONS OF EACH PARAGRAPH BY PLACING YOUR INITIALS AT THE END OF EACH PARAGRAPH. IF YOU HAVE ANY QUESTIONS REGARDING THESE PARAGRAPHS, CONTACT THE EMPLOYER BEFORE INITIALING THE PARAGRAPH.

****

1. I understand and accept that, if I am selected for employment, my employment may be conditioned upon my passing any medical examination that the employer deems necessary to determine whether I can physically perform the essential functions of the position, with reasonable accommodation when necessary. I understand and accept that this may include drug, alcohol or substance abuse testing. Initials:_____

2. If employed, I understand and accept that, depending on the department in which I am applying for employment, I may be required to work evening shifts or night shifts, including weekends and be on call and work mandatory overtime hours. Initials:_____

3. I understand and accept that if any information required in this application is found to be falsified or intentionally excluded, my application may be disqualified from further consideration. I further understand and accept that if I am employed by an Appointing Authority of Belmont County, I may be subject to disciplinary action, including termination, if any information required by this application has been falsified or intentionally excluded. Initials:_____

4. I understand and accept that the employer requires a high degree of integrity and confidentiality of its employees. I also understand and accept that the various law enforcement and informational agencies that exchange information and data with the employer require that the employer's employees do not have a past record of unlawful activities. Therefore, I understand and accept that, depending on the department in which I am applying for employment, it may be necessary for the employer to investigate my background for any criminal or unlawful activity. Initials:_____

5. I hereby authorize the employers, schools and personal references named in this application to provide information regarding me to the employer. I further authorize the release of personnel, academic and other records to the employer. Initials:_____

6. READ CAREFULLY BEFORE INITIALING
"I agree that any claim or lawsuit relating to my service with Belmont County or any of its subsidiaries must be filed no more than six (6) months after the date of the employment action that is the subject of the claim or lawsuit. I waive any statute of limitations to the contrary." Initials:_____

I SOLEMNLY SWEAR THAT ALL OF THE INFORMATION FURNISHED IN THIS EMPLOYMENT APPLICATION IS TRUE, ACCURATE, AND COMPLETE TO THE BEST OF MY KNOWLEDGE. I AUTHORIZE INVESTIGATION OF ALL STATEMENTS CONTAINED IN THIS APPLICATION. I UNDERSTAND THAT ANY MISREPRESENTATION OR FALSIFICATION OF THE INFORMATION PROVIDED MAY LEAD TO WITHDRAWAL OF AN EMPLOYMENT OFFER OR TERMINATION FOLLOWING EMPLOYMENT. I RECOGNIZE THAT MY FUTURE EMPLOYMENT WITH THE EMPLOYER WILL BE JEOPARDIZED IF I ENGAGE IN SUBSTANCE ABUSE, ILLEGAL DRUG USE, OR ALCOHOL ABUSE.

_____ _____
(Applicant's Signature) (Date)

_____ _____
(Notarized by) (Date)

****
*

EEO DATA: VOLUNTARY DISCLOSURE FORM

Regulations of the Equal Employment Opportunity Commission (EEOC) require employers to compile data regarding the nature and make-up of their work forces in order to further the goals of Title VII of the Civil Rights Act of 1964, as amended. Your responses to the following questions will help the employer comply with this requirement. Completion of this questionnaire is entirely voluntary on your part. Should you opt to complete the questionnaire, your response will be used by the employer solely for the purposes of preparing the reports required by the EEOC. Your response will be kept confidential, and will play no part in the employer's evaluation of your employment performance or status, or your treatment as an employee. The completed questionnaire will be kept separate from your personnel file.

NAME:_____
AGE:_____
SEX:_____
RACIAL AND ETHNIC CATEGORIES:

- ☐ White (not of Hispanic origin)
- ☐ Black (not of Hispanic origin)
- ☐ Hispanic
- ☐ Asian or Pacific Islander
- ☐ American Indian or Alaska Native

DO NOT WRITE BELOW THIS LINE

HIRED:_____ Yes____ No____ POSITION_____

DEPT._____ SALARY/WAGE_____

DATE REPORTING TO WORK_____ SHIFT_____

(Print) LAST FIRST M.I.	DATE

Reason for Use of Sick Leave:

1. _____ Medical, Dental, or Optical Appointment[1]

2. _____ Personal Illness[2] _____

*State **exact nature** of injury*

_____

3. _____ Personal Injury[3] _____

*State **exact nature** of injury*

_____

a. Where did it occur?_____

b. When did injury occur?_____

c. Will this injury affect your ability to perform any of your required duties? _____

_____

4. _____ Illness or injury in immediate family? _____

_____

State nature of illness or injury to family member and relationship of family member

a. Briefly state why it was necessary for you to attend to this family member. _____

[1]A statement from the appropriate practitioner stating the time you were there and the reason for your appointment must be attached.

[2]If you sought medical attention for an illness or injury, you must attach the physician's statement no matter how long the absence.

[3]If injury, a statement from your physician must be attached stating the **exact nature** of your

b. Did you take this family member to a medical practitioner or a hospital?[4] _____

5. _____ On-the-job injury. Check this block if you desire to temporarily use sick leave benefits and plan to file Workers' Compensation benefits at a later date. Your supervisor will instruct you on how to file for Workers' Compensation.

6. _____ Death in Family _____
State name and relationship of family member

Date of Death_____ Date of Funeral _____

7. _____ Number of hours of sick leave requested _____
Note: Sick Leave must be taken in units of whole hours

8. _____ Court: _____ Court Duty _____ Jury Duty

Subpoena issued by _____ Court _____, 20___.
(Attached copy of subpoena or order to report for Jury Duty)

9. _____ Military _____ With Pay _____ Without Pay

I do hereby certify the statements made herein to be true and factual. I understand that payment for the sick leave requested may be withheld until all information I have stated on this application is verified, and until I complied with all rules and regulations as stated on this application, and in the County's policy manual. Further, I understand that falsification of this application may constitute fraud, may result in a refund by me to the County, and may be cause for discipline, including dismissal.

_____
Signature of Employee

---

injury, and that you can return to work.

[4]A statement from the attending physician or from the hospital that your attendance with a family member was **necessary** must be attached.

DO NOT WRITE BELOW THIS LINE

Administrative Action: ❑ Approved
❑ Not Approved

_____
Supervisor

Remarks:_____ Total Hours _____

Available Balances: _____Sick Time _____Vacation Time
_____Personal Leave _____Compensatory Time

As of _____, 20_____

_____ _____
Signature of Supervisor Date

Employee's Name: _____

Employee's Classification: _____

Date Violation Occurred: _____

Location Where Violation Occurred: _____

VIOLATION

Type of Violation: _____

Description Of Violation: _____

_____

_____

_____

_____

_____

_____

(Attach Additional Sheet If Necessary)

Instruction & Cautioning is issued as a corrective measure in an effort to help you improve your conduct. Any further violations may result in more severe disciplinary actions.

_____ _____

Signature Of Supervisor or Manager Signature of Appointing Authority

I hereby acknowledge that a copy of the above Record Of Instruction & Cautioning has been given to me this day.

_____ _____

Signature Of Employee Date

cc: Employee
Employee's Personnel File

BELMONT COUNTY
PERSONNEL POLICY MANUAL

REPORT OF WRITTEN REPRIMAND — SECTION 10.5

Employee's Name: _____

Employee's Classification: _____

Date Reprimand Was Issued: _____

VIOLATION

Date Violation Occurred: _____ Location Where Violation Occurred: _____ Describe Violation: _____

_____

(Attach Additional Pages If Necessary)

This written reprimand is issued as a corrective measure in an effort to help you improve your conduct. This warning will cease to have force or effect twenty-four (24) months from the date of issuance, provided no intervening discipline has occurred.

_____ _____
Signature of Person Issuing Warning Title

I hereby acknowledge that a copy of this written reprimand has been given to me on this date.

_____ _____
Employee's Signature Date

I hereby acknowledge that a copy of this written reprimand was presented to the above named employee on this date.

_____ _____
Witness Date

NOTICE OF PREDISCIPLINARY CONFERENCE — SECTION 10.6

This notice is provided to you to advise that a predisciplinary conference will be held at _____ at _____ on _____ to provide you with
time *location* *date*
an opportunity to respond to the following allegations of misconduct:_____

_____

_____

_____

_____

Proof of allegations at this predisciplinary conference may result in disciplinary action ranging from an oral warning or counseling up to and including possible suspension or termination of your employment. The particular discipline, if any, to be imposed will be determined by the appointing authority after a careful review of the report issued by a hearing office.

You have the right to: (1) appear at the conference to present an oral or written statement in your defense; (2) appear at the conference and have your chosen representative present an oral or written statement in your defense; or (3) elect in writing to waive your opportunity to have a predisciplinary conference.

If you elect to attend the conference and present any evidence in your defense, or if you are called to testify as to these matters by the appointing authority, you must answer all questions truthfully. If it is proved in a subsequent hearing that your responses to questions were not truthful, such dishonesty may result in further disciplinary action.

At the conference you may present any explanation of the alleged misconduct. A written report will be prepared by the person conducting the conference concluding as to whether or not the alleged misconduct occurred. A copy of this report will be provided to you within five (5) days following its preparation.

The predisciplinary conference will be conducted by_____.

If you have any questions in regard to this procedure, please contact this individual immediately.

I acknowledge receipt of this notice on:_____, 20___.

Signature_____

I acknowledge receipt of this notice on:_____, 20___.

Witness Signature_____

COMPLAINT FORM **SECTION 10.7**

APPOINTING AUTHORITY OR DESIGNEE

Name of Employee _____

Classification _____ Unit or Dept. No._____

Date of Occurrence _____ Date Presented _____

Nature of Complaint, what is the issue or allegation, what has been violated? _____

_____

_____

Statement of facts: _____

_____

Names of any witnesses:_____

_____

Relief requested:_____

_____

Employee Signature:_____ Date _____

If complaint is a group complaint, all employees in the group shall sign on the back of form. The employee whose name appears in the above space shall process the complaint.

Complaint must be addressed verbally with the employee's immediate supervisor within five (5) working days from the date of the alleged complaint.

Supervisor_____ Date Received _____

Supervisor Answer_____ Date _____

(*Response to be issued within five (5) working days of the date on which the complaint was submitted.)*

EXIT INTERVIEW FORM **SECTION 10.8**
PAGE 1

Name _____ Department _____
Job Title _____ Termination Date _____
Date Interviewed _____ By _____ Employment Date _____
Reason for Separation _____
_____

Employee's Evaluation of the Job

	Excellent	Satisfactory	Fair	Poor	Unsatisfactory
Interest Job Held					
Performance Recognition					
Supervisory Fairness					
Chance for Advancement					
Wages and Benefits					
Rapport with Fellow Workers					
Training Received on Job					
Description of Position Compared to Actual Work					
Communication between Employees & Management					
General Working Conditions					

Employee's Comments _____
_____
Interviewer's Comments _____
_____
_____
Appointing Authority's and Supervisor's Final Evaluation of Employee _____
_____

Would We Rehire? ❑ Yes ❑ No

_____ /_____
Signature of Appointing Authority or Designee /Date

REPORT OF INJURY FORM **SECTION 10.9**
PAGE 1

(*Supervisors must report all accidents involving an injury to an employee.*)

Name of Injured Employee: _____ Age ____ Sex _____

Classification Title:_____ Department: _____

Length of Service with Department: _____ On Present Job:_____

Date of Accident: _____ Time: __ a.m. __ p.m.

Location of Accident:_____

Who advised you of accident? _____When? _____

Description of incident:_____

_____

Nature of injury and part of body involved: _____

_____

_____

Was any protective equipment being used? If yes, what type?_____

_____

What job was the employee performing when he or she was injured? (including tools, machine, and materials being used) _____

_____

Were any safety rules violated? (please explain)_____

_____

What safeguards may be used to prevent similar incidents? _____

_____

What equipment was damaged? _____

Was any first aid provided at the scene of the accident by any employee or person not licensed to practice medicine? ☐ Yes ☐ No

Did the employee see a doctor about the accident? ☐ Yes ☐ No

If yes, name of doctor: _____

Address: _____ Telephone: _____

Did the employee report to work the next scheduled day? ☐ Yes ☐ No

Name and addresses of witnesses to incident: _____

_____

_____

_____

I have completed this report and it is correct to the best of my knowledge.

_____ _____
Signature of Person Completing Form Date

I have read this report it is correct to the best of my knowledge.

_____ _____
Employee's Signature Date

This form, completed and signed by appropriate parties must be submitted within forty-eight (48) hours of the incident.

_____ _____
Signature of Appointing Authority Date

EMPLOYMENT ELIGIBILITY VERIFICATION (I-9) SECTION 10.10

INSERT I-9 FORM

STATEMENT OF SUPPORT FOR DRUG FREE POLICIES (CURRENT EMPLOYEE) SECTION 10.11

The purpose of this statement is to voluntarily demonstrate my support for a strict enforcement of Belmont County's Drug Free Workplace Policy, and the Employer's attempt to eradicate drugs in the workplace.

Signature _____ Date _____

DRUG FREE WORKPLACE STATEMENT FOR PROSPECTIVE EMPLOYEES — SECTION 10.12

The purpose of this statement is to verify that I have received a copy of the Belmont County Board of Commissioners' Drug Free Workplace Policy, and to further verify that I understand and support such policy.

I further agree to refrain from violating this policy while employed by the County.

I further acknowledge, in advance, that my understanding is that the penalty for violating this policy can be discharge, and I agree that such penalty is appropriate when supported by evidence.

Signature _____ Date _____

RECEIPT OF DRUG FREE WORKPLACE DOCUMENTATION SECTION 10.13 FOR EXISTING EMPLOYEES

This is to verify that I have been provided with a copy of the Belmont County Board of Commissioners' Drug Free Workplace Policy.

Signature _____ Date _____

Reasonable Cause / Documentation of Violation

The individual identified below is suspected of failing to comply with the Belmont County Drug Free Workplace Policy.

Employee Name_____ Location_____

List below all of the behaviors observed by the supervisor that created a concern that the employee named above might be in violation of the Employer's Drug Free Workplace Policy.

_____

_____

If there were observable changes in the employee's job performance, list these behaviors below.

_____

_____

List below any physical signs or symptoms of possible substance use that the employee exhibited.

Eyes_____
Coordination _____
Speech_____
Other_____
Other Pertinent Observations_____

_____
Supervisor Reporting_____
Title of Supervisor _____
Name of Concurring Supervisor/Managerial Witness_____
Position _____
Date_____ Time_____ Shift_____
Testing Ordered:
_____ Drugs
_____ Yes Employee Consent Yes/No Date Tested_____
_____ Alcohol
_____ No Employee Consent Yes/No
MRO Findings_____

_____
Follow-up Actions Taken_____
****
County Official's Signature_____ Date _____

Return To Duty Agreement

EMPLOYEE_____ DEPARTMENT_____

Effective_____, by agreement of all the parties, the termination of the aforementioned employee will be reduced to a final suspension, providing all conditions of the Return to Duty Agreement are completed on a timely basis. The purpose of the Agreement is to prevent any misunderstanding as to its terms, conditions, and time specified. This Agreement is specifically and individually designed to meet the needs of the employee named above and shall not be precedent setting.

I, _____, have read, understood, and agree to all of the terms of this Agreement, and fully understand that failure to comply with its terms may result in disciplinary action, up to and including termination of my employment.

I agree that:

1. I will abstain from the use of alcohol, and all psychotropic drugs (any substance or drug having a special affinity for or effect on the psyche or mind) not prescribed by my primary care physician and approved by the designated substance abuse professional. I will notify my Employer of such prescriptions. I understand that abuse of such prescriptions will be a violation of the Agreement.

2. I will enter rehabilitation treatment at _____. I consent to the issuance of progress reports to the designated representative if the Belmont County Board of Commissioners.

3. I will complete the intensive phase of treatment with approval of the substance abuse professional.

4. I will attend the continuing care program at _____ for no less than one year.

5. I will attend AA/NA meetings and support group weekly for minimally one (1) year as recommended by the substance abuse professional.

6. I will have the AA/NA group secretary or support group facilitator attest to my attendance on a record card. Further, I will submit that record card to the designated employer representative on a weekly basis as stated in statement #2.

Return To Duty Agreement
(Continued)

7. I will submit to testing for drugs and alcohol prior to my return to work. My Employer may require that I submit myself to a minimum of six (6) follow-up drug tests within the twenty-four (24) month period immediately following my return to duty and may require additional tests for up to sixty (60) months.

The application of this Agreement shall be not subject to the grievance and arbitration procedures set forth in the collective bargaining agreement.

By their signatures, the Employer and Union acknowledge that the aforementioned employee has had the terms of this Agreement explained to him/her, that he/she has willingly agreed to them, and that they have witnessed his/her signature on this Agreement.

Employee	Date
Employer	Date
Union Representative (if applicable)	Date

SICK LEAVE CONVERSION UPON RETIREMENT FORM SECTION 10.16

Name _____

Classification/Rate of Pay _____ Department _____

Check One

☐ I would like to be paid for my accumulated sick leave. I realize that this payment will be based on my current rate of pay, and that my entire sick leave credit will be eliminated.

☐ I would like to retain my accrued sick leave.

☐ Not eligible for sick leave conversion.

Signature of Employee_____ Date_____

☐ Approved ☐ Disapproved

Signature of Appointing Authority_____

EEO/ADA COMPLAINT FORM — SECTION 10.17

A. Complainant must fill out this portion and give to the EEO/Personnel Officer within ten (10) working days of the incident being complained about.

Name of Complainant _____

Classification (Position Applied For) _____

Address (If Non-Employee) _____

County Department (If An Employee) _____

Reason for Claiming Discrimination Based on Disability (Continue on Back If Necessary) _____

_____

Date Of Incident _____

Nature of Disability _____

Resolution You Request _____

Signature and Date _____

B. EEO/Personnel Officer (answer within ten (10) working days)

Resolution Or Disposition _____

Note: Keep on file for three (3) years; six (6) years for employee complaints.

FAMILY MEDICAL LEAVE REQUEST FORM — SECTION 10.18

Employee Name:_____ Date:_____

Leave Requested: *(Check One)*

☐ Due to birth of child of employee;
☐ Due to placement of child with the employee for adoption/foster care;
☐ In order to care for:_____
(Name of Person)

(*must be spouse, child, parent or person "in loco parentis" to employee*) Who has the following serious health condition: _____

_____
(*State Exact Nature of Health Condition)*

☐ Because of the following serious health condition that renders employee unable to perform the essential functions of the employee's position._____

_____
(State Exact Nature of Health Condition)

Beginning date/time of leave _____
Ending date/time of leave _____
Total hours of leave requested _____

☐ If leave is due to serious health condition of employee or member of immediate family, Section 10.17, Certification of Health Care Provider must be completed and attached hereto.

I certify all statements herein to be complete and true. Falsification is cause for discipline up to and including termination of employment.

_____
Signature of Employee

Administrative Action

☐ Order Second Opinion to Certification **Or**

☐ Approved ☐ Not Approved Because:_____

_____
Signature

FAMILY MEDICAL LEAVE NOTIFICATION FORM — SECTION 10.19

This notice is provided to you in response to your request for Family and Medical Leave and is intended to describe your rights and obligations under your leave.

1. You are entitled to 12 weeks of Family and Medical Leave (FML) measured forward from the date the employee's first family medical leave begins. Your current FML balance is: _____ days & hours

2. Before taking FML, you must exhaust all applicable accrued paid leave:

earned vacation leave	_____ hours
accrued sick leave (if applicable)	_____ hours
compensatory time	_____ hours
	_____ total hours

3. After exhaustion of your accrued paid leave, you shall be eligible to take ___ hours of Family and Medical Leave beginning _____, 20__ and ending _____, 20__.

4. For the duration of your leave, your current group health insurance coverage will be maintained so long as you pay your portion of the premium. $_____ is due at the Belmont County Auditor's Office by the last day of the month beginning _____, 20__ and ending _____, 20__. Failure to pay said amounts within 30 days of the due date will result in termination of the Employer's obligation to pay its share of the premium for your coverage.

5. If your FML is due to a serious health condition which has rendered you unable to perform the essential functions of your position, you will be required to present a certification from your physician stating you are fit to return to duty before resuming work.

6. Upon return to work, you will be restored to your original position or a position with equivalent pay, benefits and other terms of employment.

7. If you elect not to return to work at the expiration of your FML, you will be liable to repay the Employer's share of all premiums paid on your behalf while on FML.

APPROVED

Date:_____ Name:_____

Signature:_____

BELMONT COUNTY
PERSONNEL POLICY MANUAL

EMPLOYEE'S REPORT OF BACK INJURY — SECTION 10.20

(This form is to be completed and submitted with Section 10.9, Report of Injury Form, to Supervisor when injury is to an employee's back)

Employee Name:_____

Name of Employer:_____

1. What part of your back hurts now?_____
2. When did you first notice this back pain (date & time)?_____
3. What did you feel?_____
4. What were you doing at that time? (explain in detail):_____
   _____
5. If you were lifting an object, what was it and how heavy?_____
   _____
6. What was your exact position when pain was first noticed?_____
   _____
7. What was the length of time between the injury and your disability?_____
   _____
8. Did anyone see you get hurt? __ Give name:_____
9. Did you report or mention this injury to anyone?_____
   Who and when?_____
10. Did you ever have a back injury before?_____
11. If so, when?_____ What part of your back?_____
12. Were you treated by a doctor?_____ Date:_____
13. Has it given further trouble?_____
14. Have you ever received or filed for compensation because of a back injury?_____
    Other injury?_____

By signing this form I expressly waive all provisions of law which forbid any person or persons who heretofore did or who hereafter may medically attend, treat, or examine me or who may have information of any kind which may be used to render a decision in my claim for injury/disease of _____, 20__ from disclosing such knowledge to my employer and/or Comp Management, Inc. (representative of employer). A copy of this form will serve same as the original.

Employee Signature_____ Date_____

(Print Name)_____

SUPERVISOR'S REPORT:

Exceptions:_____
_____
_____
_____

Supervisor's signature is verification that the validity and completeness of the above statement has been checked.

Date completed:_____

WORKPLACE SAFETY AND ILLEGAL ACTIVITY ACKNOWLEDGEMENT — SECTION 10.21

The employee understands and accepts that all of the Employer's employees share responsibility for maintaining a safe workplace and a workplace free from illegal activity. Therefore, the employee has an obligation to obey and enforce workplace safety rules and to immediately contact a supervisor if the employee becomes aware of potential or evident safety problems in the workplace. Furthermore, all employees are required to inform the Employer of any evidence of wrongdoing or waste in the workplace by a fellow employee or supervisor, and to do so before reporting the issue to other authorities, pursuant to the requirements of Ohio law.

_____ _____

Employee's Signature Date

WORKPLACE SAFETY REPORT FORM — SECTION 10.22

Dept./Office:_____ Date:_____

Location and nature of rules or workplace safety violation:_____

_____

_____

_____

_____

_____

My suggested remedy(ies):_____

_____

_____

_____

_____

_____

Date_____ Employee's Signature_____

SUPERVISOR'S REPLY TO EMPLOYEE

_____

_____

_____

_____

_____

_____ _____

Date Supervisor's Signature

ACKNOWLEDGEMENT OF RECEIPT OF O.R.C. CHAPTER 102 — SECTION 10.23

Please sign below and present this acknowledgement slip to your Appointing Authority for inclusion in your personnel file.

I hereby acknowledge that I have received a copy of O.R.C. Chapter 102 ─ Public Officers ─ Ethics, and O.R.C. Section 2921.42. By my signature below, I hereby acknowledge that if I break these provisions of the law, I could be subject to criminal prosecution and/or discipline including termination of my employment.

_____
Signature of Employee

_____
Date

OHIO ETHICS LAW AND RELATED STATUTES SECTION 10.24

In order to read the Ohio Ethics Law and Related Statutes, go to the following web link:

http://www.ethics.ohio.gov/ethicslawrevisedcode.html

If you are unable to access the web link, the Employer can provide you with a hard copy of the document to review.

WORKPLACE VIOLENCE INCIDENT REPORT — SECTION 10.25

Date of incident: _____

Facts of Incident: _____

_____

_____

_____

Statement(s) of Witnesses:

1. _____

_____

_____

Signature of Witnesses: _____

2. _____

_____

_____

Signature of Witnesses: _____

3. _____

_____

_____

Signature of Witnesses: _____

4. _____

_____

_____

Signature of Witnesses: _____

Proposed Action To Prevent Situation From Occurring Again: _____

_____

_____

_____

Signature of Supervisor or Department Head: _____

Date: _____

OHIO BUREAU OF MOTOR VEHICLES CRASH REPORT **SECTION 10.26**

INSERT FORM

SUPERVISOR'S ACCIDENT INVESTIGATION REPORT 10.27

Name of Injured:_____ Sex:_____ Age:_____

Home Address:_____

Social Security Number:_____ Date of Accident:_____

Nature of injury and body part(s):_____

_____

Occupation:_____

Occupation at time of injury:_____

Case numbers or names of same accident:_____ Time of injury:_____

On Premises:___ Specific Location:_____

Name and address of treating facility:_____

_____

Describe how accident happened:_____

_____

_____

_____

Accident sequence: Describe in reverse order of occurrence events preceding the injury and accident, starting with the injury and moving backward in time reconstruct the sequence of events that led to the injury.

A. Injury event:_____

B. Accident event:_____

C. Preceding event #1:_____

D. Preceding event #2:_____

Severity of injury: (Circle)

Fatality Lost workdays Medical treatment First aid Other_____

Supervision at time of accident: (Circle)

Directly supervised Not supervised Indirectly supervised Not feasible

Task and activity at time of accident:_____

Employee was working: (Circle) Alone Group Other:_____

Casual factors, events, and conditions that contributed to the accident:_____

_____

_____

_____

_____

Corrective action:_____

_____

_____

_____

Responsible person:_____

_____

_____

_____

_____

Accident Investigation Team:

A. Supervisor:_____

B. Injured Person (when possible):_____

C. Safety Committee Member:_____

D. Safety Department Representative:_____

DMA FORM **SECTION 10.28**
PAGE 1

SEE FOLLOWING PAGE

The DMA Form can be found at:

http://homelandsecurity.ohio.gov/dma_terrorist/HLS%200037%20Public%20Employment%202-06.pdf