SCHOOL SECRETARY EVALUATION FORM

The secretary's evaluation will be based on how well s/he scores on each of the responsibilities listed below. Scoring on each item will reflect:

4 - Highly Effective
3 - Effective
2 - Needs Improvement
1 - Ineffective

I. Professional Duties and Responsibilities

___ Perform duties of receptionist and maintain a pleasant attitude; receive telephone calls, respond appropriately and correctly, and make proper disposition of such.

___ Maintain respect at all times for confidential information.

___ Effectively operate various office machines.

___ Type schedules, newsletters, grade cards; responsible for transcribing and typing correspondence, reports, charts, student records, and so forth.

___ Arrange/record appointments for the principal and other staff if necessary.

___ Conduct contacts with the public/community and others with tact and diplomacy.

___ Call parents of students on absence list if the parents have not reported their child's absence.

___ Collect, count, and forward all monies for deposit.

___ Assist injured or sick students when necessary.

___ Assist in dispensing supplies to staff.

___ Sort and distribute incoming and/or daily mail.

___ Assist with attendance records; weekly and grading period totals; yearly report.

___ Maintain Student Record files, current student index card system; includes transfers and withdrawal students.

II. Other Responsibilities

___ Serve as a role model for students in how to conduct themselves as citizens and as responsible, intelligent human beings.

___ Conduct other duties related assigned by the building principal and/or assistant principal expeditiously and with a positive attitude.

Evaluators Comments

Secretary's Comments

The secretary's signature indicates only that all phases of the appraisal have been conducted.

_____ _____
Secretary's Signature Date

_____ _____
Principal's Signature Date

REPORT OF HARASSMENT

Employee Name: _____ Date of Report: _____

Employee Position: _____

Date of Alleged Harassment: _____

Location of Alleged Harassment: _____

Name of Alleged Harasser: _____

Position: _____

Department or School: _____

Description of the Incident(s): _____

_____

_____

_____

_____

_____

Names of Witness(es), if any: _____

_____

_____

_____

_____

_____

_____

_____
Signature of Person Making the Report

_____
Signature of Person Taking the Report

(over)

Date of Action Taken: _____

Action Taken: _____

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Resolution: _____

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REQUEST FOR CERTIFICATE OF HEALTH COVERAGE

Name of Participant: _____ Date: _____

Address: _____

Telephone Number: _____

Name and relationship of any dependents for whom certificates are requested (and their address if different from above):

_____

_____

_____

CERTIFICATE OF GROUP HEALTH PLAN COVERAGE

*IMPORTANT – This certificate provides evidence of your prior health coverage. You may need to furnish this certificate if you become eligible under a group health plan that excludes coverage for certain medical conditions that you have before you enroll. This certificate may need to be provided if medical advice, diagnosis, care, or treatment was recommended or received for the condition within the six (6) month period prior to your enrollment in the new plan. If you become covered under another group health plan, check with the plan administrator to see if you need to provide this certificate. You may also need this certificate to buy, for yourself or your family, an insurance policy that does not exclude coverage for medical conditions that are present before you enroll.

A. Date of this certificate: _____

B. Name of group health plan: _____

C. Name of participant: _____

D. Identification number of participant: _____

E, Name of any dependents to whom this certificate applies: _____

F. Name, address, and telephone number of plan administrator or issuer responsible for providing this certificate:

_____

_____

_____

G. For further information, call: _____

H. If the individual(s) identified in line “C” and line “E” has at least eighteen (18) months of creditable coverage (disregarding periods of coverage before a sixty-three (63) day break), check here _____ and skip lines “I” and “J”.

I. Date waiting period of affiliation period (if any) began: _____

J. Date coverage began: _____

K. Date coverage ended: _____ (or checked if coverage is continuing as of the date of this certificate; _____).

Note: Separate certificates will be furnished if information is not identical for the participant and each beneficary.

FAMILY LEAVE REQUEST FORM

Name: _____ Date: _____

School: _____ Number of Days Requested: _____

Date(s) of Leave: Beginning _____ through _____

Type of Leave (check one)

_____ Serious personal health condition

_____ Serious health condition of family member

_____ Childbirth

_____ Adoption or foster care of a child

I understand the policy of the Board of Education regarding family leave and agree to abide by its provisions.

[ ] (Copy attached)

_____

Employee's Signature Date

_____

Supervisor's Signature Date

_____

Superintendent's Approval Date

CERTIFICATION OF HEALTH CARE PROVIDER
Family & Medical Leave Act (FMLA

1. Employee's Name:

2. Patient's Name (if different from employee):

3. The attached sheet describes what is meant by a "serious health condition" under the Family and Medical Leave Act. Does the patient's condition[1] qualify under any of the categories described? If so, please check the applicable category.

   (1) ____ (2) ____ (3) ____ (4) ____ (5) ____ (6) ____, or None of the above ____.

4. Describe the medical facts which support your certification, including a brief statement as to how the medical facts meet the criteria or one of these categories:

5. a. State the approximate date the condition commenced, and the probable duration of the condition (and also the probable duration of the patient's present incapacity if different):

   b. Will it be necessary for the employee to work intermittently or to work on a less than full schedule as a result of the condition (including for treatment described in Item 6 below)? _____

   If yes, give the probable duration:

   c. If the condition is a chronic condition (condition #4) or pregnancy, state whether the patient is presently incapacitated[2] and the likely duration and frequency of episodes of incapacity[2]:

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[1]Here and elsewhere on this form, the information sought relates only to the condition for which the employee is taking FMLA leave.

[2]"Incapacity," for purposes of FMLA, is defined to mean inability to work, attend school or perform other regular daily activities due to the serious health condition, treatment therefor, or recovery therefrom.

6. a. If additional treatments will be required for the condition, provide an estimate of the probable number of such treatments:

If the patient will be absent from work or other daily activities because of treatment on an intermittent or part-time basis, also provide an estimate of the probable number and interval between such treatments, actual or estimated dates of treatment if known, and period required for recovery if any:

b. If any of these treatments will be provided by another provider of health services (e.g., physical therapist), please state the nature of the treatments:

c. If a regiment of continuing treatment by the patient is required under your supervision, provide a general description of such regimen (e.g., prescription drugs, physical therapy requiring special equipment):

7. a. If medical leave is required for the employee's absence from work because of the employee's own condition (including absences due to pregnancy or a chronic condition), is the employee unable to perform work of any kind? _____

b. If able to perform some work, is the employee unable to perform any one or more of the essential functions of the employee's job based on the position description listing essential job functions? If yes, please list the essential functions the employee is unable to perform:

c. If neither (a.) nor (b.) applies, is it necessary for the employee to be absent from work for treatment?_____

8. a. If leave is required to care for an employee's family member with a serious health condition, does the patient require assistance for basic medical or personal needs or safety, or for transportation?_____

b. If no, would the employee's presence to provide psychological comfort be beneficial to the patient or assist in the patient's recovery?_____

c. If the patient will need care only intermittently or on a part-time basis, please indicate the probable duration of this need:

_____ _____
(Signature of Health Care Provider) (Type of Practice)

_____ _____
(Address) (Telephone Number)

To be completed by the employee needing family leave to care for a family member:

State the care you will provide and an estimate of the period during which care will be provided, including a schedule if leave is to be taken intermittently or if it will be necessary for you to work less than a full schedule:

_____ _____
(Employee Signature) (Date)

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

1. Hospital Care

Inpatient care (i.e., an overnight stay) in a hospital, hospice, or residential medical care facility, including any period of incapacity[2], or subsequent treatment in connection with or consequent to such inpatient care.

2. Absence Plus Treatment

(a) A period of incapacity[2] of more than three (3) consecutive calendar days (including any subsequent treatment or period of incapacity[2] relating to the same condition), that also involves:

(1) treatment[3] two (2) or more times by a health care provider, by a nurse or physician's assistant under direct supervision of a health care provider, or by a provider of health care services (e.g., physical therapist) under orders of, or on referral by, a health care provider, or

(2) treatment by a health care provider on at least one occasion which results in a regimen of continuing treatment[4] under the supervision of the health care provider.

3. Pregnancy

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

4. Chronic Conditions Requiring Treatments

A chronic condition which:

(1) requires periodic visits for treatment by a health care provider, or by a nurse or physician's assistant under direct supervision of a health care provider;

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

(3) may cause episodic rather than a continuing period of incapacity[2] (e.g., asthma, diabetes, epilepsy, etc.).

5. Permanent/Long-Term Conditions Requiring Supervision

A period of incapacity[2] which is permanent or long-term due to the condition for which treatment may not be effective. The employee or family member must be under the continuing supervision of, but need not be receiving active treatment by, a health care provider. Examples includes Alzheimer's, a severe stroke, or the terminal stages of a disease.

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[3]Treatment includes examinations to determine if a serious condition exists and evaluations of the condition. Treatment does not include routine physical examinations, eye examinations, or dental examinations.

[4]A regimen of continuing treatment includes, for example, a course of prescription medication (e.g., an antibiotic) or therapy requiring special equipment to resolve or alleviate the health condition. A regimen of treatment does not include the taking of over-the-counter medications such as aspirin, antihistamines, or salves; or bed rest, drinking fluids, exercise, and other similar activities that can be initiated without a visit to a health care provider.

6. Multiple Treatments (Nonchronic Conditions)

Any period of absence to receive multiple treatments (including any period of recovery therefrom) by a health care provider or by a provider of health care services under orders of, or on referral by, a health care provider, either for restorative surgery after an accident or other injury, or for a condition that would likely result in a period of incapacity[2] of more than three (3) consecutive calendar days in the absence of medical intervention or treatment, such as cancer (chemotherapy, radiation, etc.), severe arthritis (physical therapy), kidney disease (dialysis).

FAMILY & MEDICAL LEAVE ACT (FMLA)

Employer Response to Employee
Request for Family or Medical Leave

DATE:

TO: _____
(Employee's name)

FROM: _____
(Name of appropriate employer representative)

SUBJECT: Request for FMLA Leave

On _____, you notified us of your need to take FMLA leave due to:
(date)

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

_____ a serious health condition that makes you unable to perform the essential functions of your job; or

_____ a serious health condition affecting your ____ spouse, _____ child, ____ parent, for which you are needed to provide care.

You notified us that you need this leave beginning on _____ and that you expect leave to (date) continue until on or about _____.
(date)

Except as explained below, you have a right under the FMLA for up to twelve (12) weeks of unpaid leave in a twelve (12) month period for the reasons listed above. Your health benefits will be maintained during the FMLA leave under the same conditions as if you continued to work, and you will be reinstated to the same or an equivalent job with the same pay, benefits, and terms and conditions of employment on your timely return from FMLA leave. If you do not return to work following FMLA leave for a reason other than: (1) the continuation, recurrence, or onset of a serious health condition which would entitle you to FMLA leave; or (2) other circumstances beyond your control, you may be required to reimburse us for health insurance premiums paid on your behalf during the FMLA leave.

This is to inform you that: (check appropriate boxes; explain where indicated)

1. You are _____ eligible _____ not eligible for leave under the FMLA.

2. The requested leave _____ will _____ will not be counted against your annual FMLA leave entitlement.

3. You _____ will _____ will not be required to furnish medical certification of a serious health condition. If required, you must furnish certification _____ (insert date) (must be at least fifteen (15) days after you are notified of this requirement) or we may delay the commencement of your leave until the certification is submitted.

4. We will require that you substitute accrued paid leave for unpaid FMLA leave. If paid leave will be used the following conditions will apply: (Explain)

   (a) Since you normally pay a portion of the premiums for your health insurance, these payments will continue during the period of FMLA leave. Arrangements for payment have been discussed with you and it is agreed that you will make premium payments as follows:

   (b) You have a minimum thirty (30) day grace period in which to make premium payments. If payment is not made timely, your group health insurance may be cancelled, provided we notify you in writing at least fifteen (15) days before the date that your health coverage will lapse, or, at our option, we may pay your share of the premiums during FMLA leave, and recover these payments from you upon your return to work. We _____ will _____ will not pay your share of health insurance premiums while you are on leave.

   (c) We _____ will ____ will not do the same with other benefits (e.g., life insurance, disability insurance, etc.) while you are on FMLA leave. If we do pay your premiums for other benefits, when you return from leave you _____ will _____ will not be expected to reimburse us for the payments made on your behalf.

5. You will be required to present a fitness-for-duty certificate Form 4161 F1 prior to being restored to employment. Your return to work may be delayed until the certification is provided.

   (a) You _____ are _____ are not a "key employee" as described in paragraph 825.218 of the FMLA regulations. If you are a "key employee", restoration to employment may be denied following FMLA leave on the grounds that such restoration will cause substantial and grievous economic injury to us.

   (b) We _____ have _____ have not determined that restoring you to employment at the conclusion of FMLA leave will cause substantial and grievous economic harm to us. (Explain (a) and/or (b) below. See paragraph 825.218 of the FMLA regulations.)

6. While on leave, you will be required to furnish us with periodic reports every 30 days of your status and intent to return to work unless the health care provider certifies that the condition will last longer than 30 days, in which case you must provide status reports immediately after the period your health care provider has specified is over. If the circumstances of your leave change and you are able to return to work earlier than the date indicated on this form, you will be required to notify us at least two work days prior to the date you intend to report for work.

I _____ voluntarily and freely give my consent for the Corporation's health care provider to contact my health care provider to provide clarification and authenticity for any medical documentation.

Dated: _____ _____
(Employee Signature)

Dated: _____ _____