DIOCESE OF OAKLAND
HUMAN RESOURCES DEPARTMENT
2121 Harrison Street
Oakland, CA 94612

EMPLOYEE INFORMATION FORM

NAME:	ADDRESS:
SSN:	BIRTH DATE: MARITAL STATUS:
HIRE DATE:	
DEPARTMENT:	HOME PHONE : ( )
JOB TITLE:	BUSINESS PHONE: ( )
SUPERVISOR'S NAME:	HOURS PER WEEK:

PREVIOUS POSITIONS OF PAID EMPLOYMENT WITHIN THIS AND/OR OTHER DIOCESES:

TITLE PLACE OF EMPLOYMENT DATES

Mo./Year

_____

_____

_____

_____

_____

_____

EMERGENCY CONTACTS

PRIMARY CONTACT	ALTERNATE CONTACT (out of area)
NAME:	NAME:
ADDRESS:	ADDRESS:
PHONE: ( )	PHONE: ( )

PHYSICIAN

PHYSICIAN:
ADDRESS:
PHONE: ( )

SAMPLE (EXEMPT)
LETTER OF AGREEMENT

Date

Mr./ Ms./ Mrs.

, CA 94

Dear :

I am happy to offer you the position of _____ for the Diocese of Oakland. As we agreed, your start date will be _____.

This is a full-time exempt position, which may sometimes require work outside the normal Monday through Friday standard.

Personnel policies for chancery employees note that we serve an initial six-month probationary employment period, which may be extended an additional three months at the discretion of the supervisor. During the initial probationary period, employment is "at will". If you successfully complete the probationary period you will be moved to regular status. At that time the employment relationship may end by job closure, termination for cause or voluntary termination. This is more fully outlined in the Chancery/Parish Personnel Policies which can be viewed on the Diocese of Oakland website.

Your starting salary will be $_____ monthly. Your salary classification is _____. Salary increases are considered annually, by the method specified within the compensation plan.

You are eligible for the current employment benefits. Benefits are specified in the chancery personnel policies and include the following: three weeks vacation per year, increasing to four weeks after completion of the seventh year of employment; 13 paid holidays; paid sick leave, accrued at the rate of one day per month to a maximum of 60 days; disability insurance; life insurance [$25K]; medical, dental and vision insurance for yourself, to be effective _____; eligibility for dependent coverage on diocesan health plans, at your own expense; participation in the diocesan retirement program (employer contribution of 8% of salary, subject to a vesting period of 3-5 years, with contributions to begin _____. See appendices A and B of the Chancery/Parish Personnel Policies for fuller explanation of benefits and retirement program.

Employment is subject to the terms and conditions of the Chancery/Parish Personnel Policies, which may be modified with the approval of the Bishop at any time.

A copy of the Diocesan Dispute Resolution Process can be obtained from the Diocese of Oakland website. By signing this letter you agree to be bound to those procedures for all matters within the scope of review under those procedures. Note that these procedures are not available to you while you are a probationary employee.

Additionally, on your first day of work you will need to complete the Immigration and Naturalization Service's I-9 form. Please bring documentation with you that will provide proof of your identity and, if needed, proof of work authorization so that we can complete the employer's portion of the form. You will also need to be fingerprinted if you have not already done so for the Diocese of Oakland.

This agreement supersedes any prior or contemporaneous written or oral agreements between you and any employee or other representative of the Diocese of Oakland. Once you accept this offer, any other agreements will not apply to your employment. If you believe there is an omission in this letter offer, please bring it to my attention so that any necessary corrections can be made before you accept this offer. Also, after accepting this offer, any changes will be valid only if they are made in writing and signed by the Bishop or by your division director on behalf of the Bishop, or if they are made pursuant to terms of the Chancery/Parish Personnel Policies.

You will be required to sign this agreement as a condition of your employment.
Please sign the space provided below indicating that you accept our offer and return a copy to me at your earliest convenience.

Welcome to the Diocese of Oakland!

Sincerely

Name	Penny Pendola, Ed.D
Title	Director of Human Resources

I ACCEPT EMPLOYMENT WITH THE DIOCESE OF OAKLAND UNDER TERMS AND CONDITIONS NOTED IN THIS LETTER.

_____ DATE: _____

C: PERSONNEL FILE

SAMPLE (NON-EXEMPT)
LETTER OF AGREEMENT

Date

Mr./ Ms./ Mrs.

, CA 94

Dear :

I am happy to offer you the position of _____ for the Diocese of Oakland. As we agreed, your start date will be _____.

This is a full-time non-exempt position of 37.5 hours per week, Monday – Friday. Should overtime be required, it will be compensated according to California and Federal laws regarding overtime compensation.

Personnel policies for chancery employees note that we serve an initial six-month probationary employment period, which may be extended an additional three months at the discretion of the supervisor. During the initial probationary period, employment is "at will". If you successfully complete the probationary period you will be moved to regular status. At that time the employment relationship may end by job closure, termination for cause or voluntary termination. This is more fully outlined in the Chancery/Parish Personnel Policies which can be viewed on the Diocese of Oakland website.

Your starting salary will be $_____ per hour. Your salary classification is _____. Salary increases are considered annually, by the method specified within the compensation plan.

You are eligible for the current employment benefits. Benefits are specified in the chancery personnel policies and include the following: three weeks vacation per year, increasing to four weeks after completion of the tenth year of employment; 13 paid holidays; paid sick leave, accrued at the rate of one day per month to a maximum of 60 days; disability insurance; life insurance [$25K]; medical, dental and vision insurance for yourself, to be effective _____; Eligibility for dependent coverage on diocesan health plans, at your own expense; participation in the diocesan retirement program (employer contribution of 8% of salary, subject to a vesting period of 3-5 years, with contributions to begin _____. See appendices A and B of the Chancery/Parish Personnel Policies for fuller explanation of benefits and retirement program.

Employment is subject to the terms and conditions of the Chancery/Parish Personnel Policies, which may be modified with the approval of the Bishop at any time.

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Welcome to the Diocese of Oakland!

Sincerely

Name	Penny Pendola, Ed.D
Title	Director of Human Resources

I ACCEPT EMPLOYMENT WITH THE DIOCESE OF OAKLAND UNDER TERMS AND CONDITIONS NOTED IN THIS LETTER.

_____ DATE: _____

C: PERSONNEL FILE

DIOCESE OF OAKLAND
NEW HIRE CHECKLIST
FOR CHANCERY / PARISHES

Employee name: Location:

Employment date: Position/classification:

1. Material for Personnel File

- o Application
- o Resume and/or transcripts
- o References: ☐ Received ☐ Checked
- o DOJ / FBI (Livescan)
- o Employment Agreement
- o Signed Employee Handbook acknowledgment
- o Job description
- o Copies of Diplomas & Degrees as appropriate

2. Immigration Data

- o I-9 (revised 8/7/09) form completed with proper ID, signed, and filed *separately*

3. Pay Information to be Completed for the Record

- o New Hire Payroll Form (to document for ADP payroll)
- o Direct deposit (if applicable)
- o W-4 for tax withholding

4. Benefit and Personnel Information

- o Employee Handbook for Parish and Chancery Personnel
- o Flex Plan Decision Making Guide
  - ▪ Lay employees – Flex Plan enrollment form enclosed in Decision Making Guide
  - ▪ Priests and religious order employees – obtain form from Benefits Administrator

  Guide to the Tax-Sheltered annuity Plan

5. Additional Information for Employee

- o Timesheet
- o Child Abuse Reporting form (where applicable)
- o Tour of premises and introductions to coworkers (supervisor)
- o Parking
- o Specifics on daily tasks (supervisor)
- o Job description
- o Name and address of emergency contact (reviewed annually)

CHILD ABUSE REPORTING ACKNOWLEDGMENT FORM

Section 11166 of the Penal Code requires any child care custodian, medical practitioner, nonmedical practitioner, or employee of a child protective agency who has knowledge of or observes a child in his or her professional capacity or within the scope of his or her employment whom he or she knows or reasonably suspects has been the victim of child abuse to report the known or suspected instance of child abuse to a child protective agency immediately or as soon as practically possible by telephone and to prepare and send a written report thereof within 36 hours of receiving the information concerning the incident.

> "Child care custodian" includes teachers; an instructional aide, a teacher's aide, or a teacher's assistant employed by any public or private school, who has been trained in the duties imposed by this article, if the school district has so warranted to the State Department of Education; a classified employee of any public school who has been trained in the duties imposed by this article, if the school has so warranted to the State Department of Education; administrative officers, supervisors of child welfare and attendance, or certified pupil personnel employees of any public or private school; administrators of a public or private day camp; licensed administrators, and employees of licensed community care or child day care facilities; head start teachers; licensing workers or licensing evaluators; public assistance workers; employees of a child care institution including, but not limited to, foster parents, group home personnel, and personnel of residential care facilities; and social workers, or probation officers; or any person who is an administrator or presenter of, or a counselor in, a child abuse prevention program in any public or private school.
>
> "Health Practitioner" includes physicians and surgeons, psychiatrists, psychologists, dentists, residents, interns, podiatrists, chiropractors, licensed nurses, dental hygienists, optometrists, or any other person who is licensed under Division 2 (commencing with Section 500) of the Business and Professions Code marriage, family and child counselors; emergency medical technicians I or II, paramedics or other persons certified pursuant to Division 2.5 (commencing with Section 1797) of the Health and Safety Code; psychological assistants registered pursuant to Section 2913 of the Business and Professions Code; marriage, family and child counselor trainees as defined in subdivision (c) of Section 4980.03 of the Business and Professions Code; unlicensed marriage, family and child counselor interns registered under Section 4980.44 of the Business and Professions Code; state or county public health employees who treat minors for venereal disease or any other condition; coroners; paramedics; and religious practitioners who diagnose, examine or treat children."

FAILURE TO COMPLY WITH THE REQUIREMENTS OF SECTION 11166 IS A MISDEMEANOR, PUNISHABLE BY UP TO SIX MONTHS IN JAIL OR BY A FINE OF ONE THOUSAND DOLLARS ($1000) OR BY BOTH.

This is to verify that I have knowledge of the provisions of Section 11166 of the penal Code and that I will comply with its provisions.

Name of Employee (Please Print): _____

Signature of Employee: _____

Date:_____

Diocese of Oakland
2121 Harrison Street * Oakland, California 94612
510.893-4711 * Fax 510.893-0945 * www.oakdiocese.org

SELF EVALUATION

ANNUAL PERFORMANCE REVIEW

Employee Name	**Time in Current Position** (years/ months)	**Job Title**
Department/Agency	**Supervisor**	**Overall Rating**

PERFORMANCE REVIEW GUIDELINES: When assessing the employee performance, use the following guidelines along with the current position description and circle or check the box that most closely describes the employee's performance during the review period. You may use the "comments" areas of the form to substantiate performance levels, if you wish. If a particular performance requirement does not apply, simply indicate "N/A" in the comments area.

The following is an explanation of the performance levels used in this appraisal:

(3) EXCEEDS EXPECTATIONS
Performance exceeds most objectives and is characterized by many significant achievements. Overall contribution exceeds that of most others in a similar job title and/or job grade both as an individual and as a team member.

(2) SUCCESSFUL
Performance consistently meets the established standards and goals. Overall contribution is appropriate relative to others in a similar job title and/or job grade both as an individual and as a team member. Achievement that is expected from new employees progressing satisfactorily.

(1) IMPROVEMENT NEEDED
Performance does not fully meet job responsibilities. Additional coaching or more frequent reviews of performance may be required. Overall contribution is less than that which is expected. Significant long-term improvement is required. Areas for improvement should be documented by the supervisor on the last page of the Annual Performance Review Summary. An action plan with dates to correct the deficiency(ies) should also be attached.

Employee's Signature _____ **Date** _____

Supervisor's Signature _____ **Date** _____

GENERAL INSTRUCTIONS FOR PERFORMANCE REVIEW

SUPERVISOR RESPONSIBILITIES

The process used in the Performance Review is threefold:

- The employee is provided a Self-Performance Review form to complete and return to you (this form parallels the one you will complete);

- Considering the employee's self review, rate employee on all designated responsibilities using rating scale provided on Cover Page. **(3) Exceeds Expectations – (2) Successful – (1) Improvement Needed.** Use **N/A** if the task or skill does not apply to the individual. Add comments when clarification of rating is required. This must be done whenever the rating indicates that improvement is needed.

  Count the number of times you used each of these performance levels and write total on lines provided (Total number of Exceeds Expectations, Total Number of Successful, etc.) Determine which of the three ratings the employee received the **most often.** This will determine the Overall Rating to be entered on the cover page only after completing the review. For example, if the employee received a majority of Successful Ratings, the Overall Rating on the cover sheet would be "Successful".

- Conduct an in-person meeting with staff member to discuss each of the following:

  1. Ratings on individual job responsibilities
  2. Major Accomplishments as specified by employee
  3. Determine major Project and Developmental Goals and record on PAGE 7

Finally, performance review should be augmented by regular discussions between you and your employee throughout the review period to monitor progress, clarify expectations, and realign goals/objectives in support of department/chancery mission.

EMPLOYEE RESPONSIBILITIES

- Complete Self Performance Review and return to your supervisor.

- Meet with supervisor and review specific performance ratings with supervisor and add comments as needed.

- Formulate major Project and Developmental Goals with supervisor.

- Add general comments in Comment Section of PAGE 7 as needed.

- Retain copy of *Project and Developmental Goals* and *Action Plan* if applicable.

Please keep a copy of the completed form with required signatures for your files, give one to the employee, and send the original to the Office of Human Resources on or before the due date.

ANNUAL PERFORMANCE REVIEW

JOB RESPONSIBILITIES
In one or two sentences, state the major functions of this position: Have the major functions of the position changed since the last review? ____Yes _____No (If yes, please attach a revised job description approved by Department Director.)

MISSION	**Employee Performance Level**	**3**	**2**	**1**
Consider your respect for Church teachings and how you demonstrate awareness and promote the mission, goals, and priorities of the Diocese. *"To know Christ better and make Him better known"*	Comments:			

HUMAN RELATIONS	**Employee Performance Level**	**3**	**2**	**1**
Consider how effectively you work with supervisor, internal and external contacts, and respond positively to situations which require collaboration; show courtesy, respect and professionalism in dealing with others. Degree to which you work with others to secure cooperation, promote teamwork and resolve conflicts appropriately.	Comments:			

JOB KNOWLEDGE	**Employee Performance Level**	**3**	**2**	**1**
Consider extent to which you effectively apply knowledge to position responsibilities; keep abreast of new developments in field of expertise; and seek opportunities for learning and self-development. Degree to which you support and adapt to changes in the work environment; and show commitment to life-long learning by continuously increasing skills, knowledge and effectiveness.	Comments:			

ANNUAL PERFORMANCE REVIEW

WORK QUALITY	Employee Performance Level	3	2	1
Consider quality and volume of your work under varying conditions and time requirements, and how you manage your own time appropriately, schedule and workflow. Your degree of skill exhibited in performing various job responsibilities that yield accurate, thorough and sound quality work results; show consistency in quality and quantity of work; and meet established deadlines.	Comments:			

PROBLEM SOLVING/CREATIVITY	Employee Performance Level	3	2	1
Consider the types of problems you encounter and the judgment used in decision-making. Do you generate new ideas and/or implement new and useful concepts effectively?	Comments:			

COMMUNICATION	Employee Performance Level	3	2	1
Consider how well you demonstrate verbal and written skills appropriate to the position. Degree to which you express ideas and information accurately and understandably and to which you listen to and understand others.	Comments:			

DECISION MAKING	Employee Performance Level	3	2	1
Consider how well you make timely and effective decisions consistent with job responsibilities and how such decisions are communicated to those individuals that need to know.	Comments:			

ANNUAL PERFORMANCE REVIEW

DEPENDABILITY	Employee Performance Level 3	2	1
Consider your punctuality. Do you arrive to work on time? Do you take excessive time for personal errands, breaks, lunch, phone calls, etc.? How well do you employee comply/adhere to sick time policy (example: sick days do not consistently fall on a Monday/Friday or before/after holidays)	Comments:		

Total Exceeds Expectations _____ Total Successful _____ Total Improvement Needed _____

ANNUAL PERFORMANCE REVIEW ACHIEVEMENT SUMMARY

NAME **DATE**

LIST MAJOR ACCOMPLISHMENTS FOR THE YEAR (MAXIMUM OF 5) – (Example: reorganized department filing system based on archive-established method.)

1.

2.

3.

4.

5.

ANNUAL PERFORMANCE REVIEW

MAJOR PROJECT GOALS

1.

2.

3.

DEVELOPMENTAL GOALS: Establish a plan to acquire the knowledge and skills needed for the employee to improve.

1.

2.

3.

EMPLOYEE'S GENERAL COMMENTS (Completed after review).

SUPERVISOR'S GENERAL COMMENTS (Completed after review).

Performance Review Action Plan

Employee Name	Time in Current Position	Job Title

Department	Supervisor

When an employee receives a #1 "IMPROVEMENT NEEDED" in one or more areas of responsibility on the Annual Performance Review, an **Action Plan must be completed and attached to the Review**.

Area(s) in which improvement is needed should be copied in full from Annual Performance Review Summary. Enter deadline as agreed upon between employee and supervisor. Enter date of completion after employee meets requirement.

EXAMPLE: TASK/JOB RESPONSIBILITY

TASK: *Seeks professional development and shows evidence of professional growth.*

ACTION: *Employee will attend one IT Class related to job responsibilities.*

DEADLINE: June 1, 2008 **DATE COMPLETED:** _____

1.

TASK: _____

ACTION: _____

_____

DEADLINE: _____ **DATE COMPLETED:** _____

2.

TASK: _____

ACTION: _____

_____

DEADLINE: _____ **DATE COMPLETED:** _____

3.

TASK: _____

ACTION: _____

_____

DEADLINE: _____ **DATE COMPLETED:** _____

4.

TASK: _____

ACTION: _____

_____

DEADLINE: _____ **DATE COMPLETED:** _____

Diocese of Oakland

D-9

Time and Accrual Record

Month of 201

Last Name		First Name				Full Time
Department						Part Time Specify hrs. per week
Date	Reg. Hrs. Worked	Holiday	Vacation	Sick Leave	Personal Leave	Comments
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						
11						
12						
13						
14						
15						
16						
17						
18						
19						
20						
21						
22						
23						
24						
25						
26						
27						
28						
29						
30						
31						
Totals						

I certify that the above record accurately indicates hours of paid time off taken.

Employee Signature _____ Supervisor Signature_____

Diocese of Oakland

D-10

Record of Paid Time Off for Exempt Employees

Month of 201

Last Name	First Name				Full Time
Department					Part Time Specify hrs. per week
Date	Holiday	Vacation	Sick Leave	Personal Leave	Comments
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					
13					
14					
15					
16					
17					
18					
19					
20					
21					
22					
23					
24					
25					
26					
27					
28					
29					
30					
31					
Totals					

I certify that the above record accurately indicates hours of paid time off taken.

Employee Signature _____ Supervisor Signature_____

MILEAGE REIMBURSEMENT REQUEST

MONTH/YR

NAME (PRINT) _____

DEPT

DATE	PURPOSE OF TRIP	ORIGIN	DESTINATION	MILES
			TOTAL MILES	

_____
Employee Signature

_____
Supervisor Signature

Diocese of Oakland
Out of Area Travel Request Form

This form is to be completed by any diocesan employee whose out-of-area business activity will require funding of $100 or more and/or absence from the diocese for more than one day. The completed form, with the supervisor's written approval, is to be forwarded to the Finance Department prior to incurring travel expense. A copy of the approval is to be attached to each check request for each payment/reimbursement.

Employee Name: ____________________________ Department____________________

Activity or Event: ____

Location: ____

Purpose or benefit of participation in the activity or event? _______________________

Date(s) absent from the diocese? ____

Estimated cost of participation:
Transportation ______________________________

Lodging ____________________________________

Meals ______________________________________

Other (specify) ______________________________

Source of funding:
Department budget ________________________ Other (specify)___________________

Employee Signature ______________________________ Date ____________________

Supervisor Approval: _____________________________ Date ____________________

Upon return from business travel, employee will brief his/her supervisor in writing on activities and/or benefits of the trip.

Finance Department Use Only:

Date received ____________________ Initials ________________________

DIOCESE OF OAKLAND

REQUEST FOR LEAVE OF ABSENCE REPORT

Employee Name:

Department: _____ Cost Center Code:

Beginning Date of Absence: _____ Last Date of Absence:

REASON OF ABSENCE:

____ Sick Leave

____ Vacation

____ Personal Leave

____ Jury Duty

_____ Family Leave

_____ Leave Without Pay

_____ Leave of Absence

Explanation (for Sick Leave, Leave Without Pay, or Leave of Absence):

WAS ABSENT:

Requested in Advance ____ Yes ____ No

Reported on First Date Absent ____ Yes ____ No

_____

Employee Signature Date

_____

Supervisor/Department Head Signature Date

Military Leave Acknowledgment Notice

Reinstatement: You will be reinstated in accordance with applicable law for example, if your service is completed in less than five years, you will generally be eligible for reinstatement as long as you gave reasonable notice in advance of the military leave, you do not receive a dishonorable discharge, and you seek reinstatement in a timely basis in accordance with applicable law, after your service is over Employer may require documentation that these conditions have been met.

Reinstatement, whenever possible, will be to the position they would have obtained if the leave had not occurred. Your level of seniority shall be the same as if you had not been on leave.

Notice: You must notify Employer about your intent to return to work promptly after your service is completed. Those who serve for 30 days or less must report to their employer at the start of the next regularly scheduled shift following eight hours of returning directly home. Those who serve for 31-180 days must apply for reinstatement within 14 days of the end of service. Those individuals who serve more than 180 days must reapply for work within 90 days of completing service.

Pay: Generally, military leave is unpaid time off. However, all employees, if eligible, may use any accrued vacation or other paid time off during their leave.

Health Coverage: You may continue your health coverage during your military leave for up to 18 months or until the time you must notify Employer about returning to work, whichever comes first. If the leave is for 31 days or more, you must pay the entire cost of this coverage.

_____	_____	_____
Employee Signature	Employer Representative Signature	Date
_____	_____	
(PRINT NAME)	(PRINT NAME & POSITION)	

INTEGRATION OF STATE DISABILITY INSURANCE (SDI) AND SICK LEAVE

When an employee is out on State Disability Insurance and wishes to integrate SDI with their sick leave the following steps need to be taken:

A request for Time/Off/Absence Report Form should be filled out with the dates the employee will be out and returned to Human Resources. Human Resources will then inform Insurance and Benefits and Accounting when/if to stop benefits and when to reinstate them.

When an employee is out sick for more than seven (7) days with a serious illness (e.g. surgery or maternity leave) the employee may apply for SDI and integrate it to his/her sick leave. SDI pays for about 55% of salary up to a maximum of $336 per week. The Diocese will make up the difference in salary out of the employee's sick leave or vacation time in the following ways:

A. Upon receipt of SDI check the employee makes a copy and sends it to Accounting. A check for the difference in salary will be sent to the employee.
B. Employee may sign and forward SDI check to Accounting and one will issued for the full salary amount.

Sick leave is extended in this way in case more time than originally planned is needed.

Employee will continue to get paid regularly until a copy of the SDI check is received at which time adjustments will be made accordingly to following pay checks.

SDI application forms are available through local Employment Development Department (EDD) offices.

Employee's Pre-Designation of Personal Physician

(California Labor Code Section 4600)

Date: _____

To: _____, Insurance & Benefits Department
Name of Employer

Labor Code 4600 allows an employee to be treated by their personal physician in the event of an industrial injury, if they have given the employer advance written notice.

A personal physician is defined as the doctor you regularly see, who has previously directed your medical treatment, and who retains your medical records.

In the event I am injured at work and require medical treatment I designate the following as my personal physician:

Name of Physician: _____

Address: _____

_____

Phone: _____

Employee's Signature _____

SSN _____

Received by I&B _____/_____
I&B Representative Name Date Received

Diocese of Oakland
Policy of Expectations and Guidelines
for Ministry to Minors

I have read and understand the content of the Policy of Expectations and Guidelines for Ministry to Minors for the Diocese of Oakland.

I understand that as a pastoral staff member or a volunteer working with children and/or youth, I am subject to a thorough background check including criminal history.

I understand that any action inconsistent with this policy regarding minors or failure to take action mandated by this policy may result in my removal as a staff member or a volunteer with children and/or youth.

_____ _____
Name of Parish/School City

_____
Staff person/volunteer's printed name

_____ _____
Signature Date

(This signed document is to be placed in an employee's Personnel file each year. The signed forms of volunteers are to be filed in the Parish offices each year. This document is to become a permanent part of the Chancery/Parish Personnel Policy Handbook.)

Please return white and yellow copies to:
Safe Environment for Children Project
2121 Harrison Street
Oakland, CA 94612

{Sample}
DIOCESE OF OAKLAND

Supervisor's Checklist for Terminating Employees

Employee Name:_____

Department Director's Name:_____

Please review the following checklist with your employee being terminated:

Description	Check if Returned
Key to Front Door	
Key to Office and or files (if applicable)	
Cell Phone (if applicable)	
Telephone Security Code:	
Computer Password	
Other Diocesan Property: list below	
Time Sheet/Record of Paid Time Off	
Outstanding Expense Reports	
Reviewed Status on Projects, as appropriate	
E-mail/Voicemail to be turned off:	

Date:_____ Signed:_____
Department Director

Please keep a copy in the Personnel File.
Place keys in sealed envelope and label/staple envelope to this sheet.

DIOCESE OF OAKLAND
CHANCERY
REQUEST TO HIRE FORM
Position Approval

Position Information

Position Title:_____ FT_____ Regular PT_____

Department: _____ Account #: _____

Salary Range: _____

Start Date: _____ End Date (if appropriate): _____

_____ Managerial
_____ Full Time
_____ Full Time Temporary
_____ Part Time
_____ Other: _____

Funding Source

_____ Regular Budget
_____ Other (specify: _____)

Position Control

____ New or revised position (attach job description)
____ Replacement position (name of employee: _____)

Position Number: _____ Acct#: _____ Initial and Date: _____

Recruitment Efforts and Sign-Off (Reverse Side)

Date efforts approved/reviewed by Affirmative Action Officer (signature required):

Scope of Recruitment: _____ Competitive _____ FT Promotional
_____ Local _____ Regional _____ National

Advertisement: (Please attach copy of advertisement)
List recruitment efforts on reverse side.

Approvals:

Supervisor: _____ Date: _____

Department Approval/Designee: _____ Date: _____

BAC Approval: _____ Date: _____

CONFIDENTIALITY AGREEMENT

In consideration of and as a condition of my employment or independent contractor relationship, or continued employment or continued independent contractor relationship, with the Roman Catholic Bishop of Oakland, a California corporation sole (hereinafter the "Diocese"), I hereby agree as follows:

1. CONFIDENTIALITY. At all times during my employment or independent contractor relationship and thereafter, I will hold in strictest confidence and will not disclose, use, lecture upon, or publish any "Confidential Information" (defined below), except as such disclosure, use or publication may be required in connection with my work for the Diocese, or unless the Bishop of the Diocese expressly authorizes such in writing.

   The term "Confidential Information," as used herein, shall mean any and all non-public information (whether in written, oral, or any other form) that I have produced, receive, or otherwise become privy to and/or in the future may produce, receive, or otherwise become privy to in connection with my employment or independent contractor relationship, including, but not limited to, information from or relating to third parties, including priests, parishioners, employees or independent contractors, and/or anyone or any other entity affiliated with the Diocese in any way.

   The term "Confidential Information," as used herein, shall also mean non-public data, records, or other information (whether in written, oral, or any other form) produced, received, or maintained by the Diocese or any affiliate relating to: priests, parishioners, employees or independent contractors, or anyone or any other entity affiliated with the Diocese in any way; policies, procedures, finances, fundraising, budgets, software, personnel, plans, or strategies; and/or any other subject matter pertaining to the Diocese or any person or other entity affiliated with it in any way.

2. RETURN OF CONFIDENTIAL INFORMATION UPON TERMINATION. In the event of the termination of my employment or independent contractor relationship with the Diocese for any reason whatsoever, I agree to promptly deliver to the Diocese all records, materials, documents, recorded media, software, and data of any nature, and any copies thereof, pertaining to any Confidential Information or to my employment, and I will not take with me any description containing or pertaining to any Confidential Information.

3. ENTIRE AGREEMENT. I acknowledge receipt of this Agreement, and agree that with respect to the subject matter herein, it is my entire agreement with the Diocese, superseding any previous oral or written communications, representations, understandings, or agreements with the Diocese or any officer or representative thereof.
4. SEVERABILITY. In the event that any paragraph or provisions of this Agreement shall be held to be illegal or unenforceable, such paragraph or provision shall be severed from this Agreement and the entire Agreement shall not fail on account thereof, but shall otherwise remain in full force and effect.
5. MODIFICATION. This Agreement may not be changed, modified, released, discharged, abandoned, or otherwise amended, in whole or in part, except by an instrument in writing, signed by me and the Bishop of the Diocese.

_____ _____

MY SIGNATURE DATE

Diocese of Oakland
2121 Harrison Street * Oakland, California 94612
510.893-4711 * Fax 510.893-0945 * www.oakdiocese.org

EMPLOYEE DISCIPLINARY ACTION

Employee's Name: **Date:**

Nature of Violation: **___ Substandard Work** **___ Tardiness** **___ Conduct**
___ Attitude **___ Disobedience** **___ Carelessness**
___ Other

SUPERVISOR REMARKS:

Has employee been warned previously: ___ Yes ___ No

Form of Warning: ___ Verbal ___ Written

Date(s) of Warning(s):

By Whom:

EMPLOYEE'S REMARKS: ___ Attached
(The absence of any statement on your part indicates your agreement with the report as stated.)

Employee's Signature:_____ Date:_____

ACTION TO BE TAKEN:

I have read this disciplinary action and understand it.

Employee's Signature: _____ Date:_____

Supervisor's Signature: _____ Date:_____

HR Director's Signature:_____ Date:_____

EMPLOYEE'S STATEMENT SUPPORTING REQUEST FOR FAMILY LEAVE

TO BE COMPLETED BY EMPLOYEE AND SUBMITTED TO CERTIFYING HEALTH CARE PROVIDER

Where Leave Sought For Serious Health Condition Of Employee's Parent, Child, Or Spouse/Domestic Partner

1. Employee's Name: _____

2. Patient's Name: _____

If family care leave is needed to care for a seriously ill family member, state the care you will provide and an estimate of the time period during which this care will be provided. Include a schedule, if leave is to be taken intermittently or on a reduced work schedule:

_____
_____
_____
_____
_____
_____

Signature of Employee:

_____ Date: _____

Please provide completed form to certifying health care provider. Do not submit this completed Statement to employer. Do submit completed Certification of Health Care Provider to employer.

CERTIFICATION OF HEALTH CARE PROVIDER SUPPORTING
REQUEST FOR FAMILY OR MEDICAL LEAVE
TO BE COMPLETED BY HEALTH CARE PROVIDER

Employee's name:_____

Patient's Name (If other than Employee):_____

_____

Date medical condition or need for treatment commenced [NOTE: THE HEALTH CARE PROVIDER IS NOT TO DISCLOSE THE UNDERLYING DIAGNOSIS WITHOUT THE CONSENT OF THE PATIENT]:

_____

Probable duration of medical condition or need for treatment: _____

_____

The attached sheet describes what is meant by a "serious health condition" under both the federal Family and Medical Leave Act (FMLA) and the California Family Rights Act (CFRA). Does the patient's condition qualify under any of the categories described? If so, please circle the appropriate category.

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

If the certification is for the serious health condition of the employee, please answer the following:

Yes No

[ ] [ ] Is employee able to perform work of any kind? (If "No," skip next question.)

[ ] [ ] Is employee unable to perform any one or more of the essential functions of employee's position? (Answer after reviewing statement from employer of essential functions of employee's position or, if none provided, after discussing with employee.)

If the certification is for the care of the employee's family member, please answer the following:

Yes No

[ ] [ ] Does (or will) the patient require assistance for basic medical, hygiene, nutritional needs, safety, or transportation?

[ ] [ ] After review of the employee's signed statement (see attached), does the condition warrant the participation of the employee? (This participation may include psychological comfort and/or arranging for third-party care for the family member.)

If the certification is for the care of the employee's family member, please estimate the period of time care will be needed during which the employee's presence would be beneficial:

_____

_____

Please answer the following question only if the employee is asking for intermittent leave or a reduced work schedule.

Yes No

[ ] [ ] Is it medically necessary for the employee to be off work on an intermittent basis or to work less than the employee's normal work schedule in order to deal with the serious health condition of the employee or family member?

If the answer to the previous question is "yes," please indicate the estimated number of doctor's visits, and/or estimated duration of medical treatment, either by the health care practitioner or another provider of health services, upon referral from the health care provider. _____

_____

_____

Signature of Health Care Provider: Signature of Employee:

_____ _____

Title:_____ Date:_____

Address:_____

_____

_____

Date:_____

Definition of "Serious Health Condition"

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 or subsequent treatment in connection with or consequent to such inpatient care.

2. Absence Plus Treatment

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

   (1) Treatment two or more times by a health care provider, by a nurse or physician's assistant under direct supervision of a health care provider, or by a provider of health care services (*e.g.*, physical therapist) under orders of, or on referral by, a health care provider; or

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

3. Pregnancy

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

4. Chronic Conditions Requiring Treatment

   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 (*e.g.*, asthma, diabetes, epilepsy, etc.).

5. Permanent/Long-term Conditions Requiring Supervision

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

6. Multiple Treatment (Non-Chronic 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 of more than three consecutive calendar days in the absence of medical intervention or treatment, such as cancer (chemotherapy, radiation, etc.), severe arthritis (physical therapy), kidney disease (dialysis).

EMPLOYER RESPONSE TO EMPLOYEE REQUEST FOR PREGNANCY DISABILITY LEAVE, INTERMITTENT LEAVE OR REDUCED WORK SCHEDULE (PDL/FMLA/CFRA)

DATE:

TO: (Employee's Name)

FROM: (Name of appropriate employer representative)

SUBJECT: REQUEST FOR LEAVE DUE TO PREGNANCY AND BIRTH OF CHILD

On (date), you notified us of your need to do one or more of the following:

- ☐ take intermittent leave in order to attend prenatal medical appointments;
- ☐ take intermittent leave or work a reduced work schedule due to serious morning sickness or other pregnancy-related disability preventing you from performing one or more of your duties;
- ☐ take a period of leave due to a serious health condition stemming from pregnancy, childbirth or a related medical condition that makes you unable to perform the essential functions of your job; or
- ☐ take a period of leave to bond with your newborn child.

Specifically, you have notified us that you need: (to take a period of leave) or (to be off work on an intermittent basis) or (to work less than your normal work schedule) beginning on (date) and continuing until on or about (date).

The Pregnancy Disability Leave provisions of the California Fair Employment and Housing Act (PDL), the California Family Rights Act (CFRA) and the Federal Family and Medical Leave Act (FMLA) provide the entitlements described below:

Pregnancy Disability Leave Entitlements: If you are disabled by pregnancy, childbirth or a related medical condition, you are entitled to take a Pregnancy Disability Leave of up to 88 work days, depending on your period(s) of disability. (If you are a part-time employee, the maximum period of the leave would be the number of days you would normally work within a four-month period.)

FMLA/CFRA Entitlements: If you have more than 12 months of service with us and have worked at least 1250 hours in the 12-month period before the day you want to begin your leave, and work at a site where more than 50 employees work within a 75-mile radius, you may have the following additional rights under the FMLA and the CFRA:

- To have your health insurance benefits maintained during up to 12 workweeks of leave under the same conditions as if you continued to work. If you do not return to work following the leave for a reason other than the continuation, recurrence or onset of a serious health condition, or other circumstances beyond your control, you may be required to reimburse us for our share of health insurance premiums paid on your behalf during your leave (FMLA/CFRA).

- To take up to an additional 12 workweeks of unpaid leave in a 12 month period for the birth, adoption, or foster care placement of your child, or for your own serious health condition (other than pregnancy disability) or for the serious health condition of your child, parent or spouse/domestic partner (CFRA leave). This leave is in addition to the up to 88 workdays of Pregnancy Disability Leave to which you are entitled for the period during which you are actually disabled due to pregnancy, childbirth or a related medical condition. If you take CFRA leave for the birth, adoption or foster care placement of a child, this leave must be taken in periods of no less than two weeks, and conclude within one year of the birth or placement of the child.

- To take additional unpaid leave in a 12 month period to the extent your Pregnancy Disability Leave and any other leave does not exhaust your right to leave under the FMLA. Notably, among

other things, the FMLA allows an eligible employee to take up to 26 weeks of leave in a 12 month period to care for the employee's child, spouse, parent or next of kin if that person is a member of the Armed Forces of the United States and is undergoing medical treatment, recuperation, or therapy, is otherwise in outpatient status, or is otherwise on the temporary disability retired list, for an injury or illness incurred by the member in the line of duty on active duty in the Armed Forces and that may render the member medically unfit to perform the duties of the member's office, grade, rank, or rating.

- To be reinstated to the same or, in some circumstances, a comparable job with the same pay, benefits and terms and conditions of employment on your timely return from leave (PDL, FMLA/CFRA).

This is to inform you of the following: *(circle appropriate responses; explain where indicated)*

You are eligible for up to 88 work days of Pregnancy Disability Leave for the period during which you are actually disabled by pregnancy, childbirth or a related medical condition. You are (eligible/not eligible) for leave under the FMLA for this purpose. Absences prior to the birth of the child for morning sickness, prenatal care or other disability related to the pregnancy will count against this entitlement. You are (eligible/not eligible) for up to 12 additional workweeks of CFRA leave following the birth of the child to bond with the child or to care for your own serious health condition (other than pregnancy disability) or that of your parent, child or spouse. Leave taken to bond with a newborn or child placed for foster care or adoption must be taken in two-week increments and completed within a year of birth or placement of the child.

The requested leave (will/will not) be counted against your annual Pregnancy Disability Leave, FMLA and/or CFRA leave entitlement as allowed by law.

You (will/will not) be required to furnish medical certification of the fact that you are unable, because of your pregnancy, to work at all or to perform one or more of the essential functions of your job, or to do so without undue risk to yourself, the successful completion of your pregnancy, or to other persons. If required, you must furnish certification by _____ *(insert date)* (must be at least 15 days after you are notified of this requirement). If you do not furnish certification by this date, we may delay the commencement of your leave until the certification is submitted.

You may elect to substitute accrued vacation or other paid time off for otherwise unpaid portions of your Pregnancy Disability Leave. We (will/will not) require that you substitute accrued sick leave during unpaid portions of your Pregnancy Disability Leave;

If you are taking additional FMLA/CFRA leave to bond with a newborn, you (will/will not) be required to substitute vacation or other paid time off during unpaid portions of your CFRA leave.

If you are taking additional FMLA/CFRA leave to bond with a newborn, you (will/will not) be required to substitute sick leave during unpaid portions of your FMLA/CFRA leave.

You currently have the following accrued vacation or paid time off benefits and sick leave benefits available: (*list available vacation, paid time off and sick leave*).

(Explain other conditions)

(a) If you are eligible for FMLA/CFRA leave, health insurance benefits will continue during leave to the same extent and under the same conditions as if you were not on leave, but only for 12 workweeks within a 12-month period. Thus, if you normally pay a portion of the premiums for your health insurance, these payments must continue in order to continue your health insurance benefits during leave. Arrangements for payment have been discussed with you and it is agreed that you will make premium payments as follows:

(Set forth dates, e.g., the 10th of each month, or pay periods, etc., that specifically cover the agreement with the employee.)

(b) You have a minimum 30-day *(or, indicate longer period, if applicable)* grace period in which to make premium payments. If timely payment is not made, your group health insurance may be cancelled, provided we notify you in writing at least 15 days before the date that your health coverage will lapse or, at your option, we may pay your share of the premiums during FMLA/CFRA 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/CFRA 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.

You (will/will not) be required to present a fitness-for-duty certificate prior to being restored to employment. If such certification is required but not received, your return to work may be delayed until the certification is provided.

(a) You (are/are not) a "key employee" as described in the FMLA and/or CFRA regulations. If you are a "key employee," restoration to employment may be denied following FMLA and/or CFRA 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 and/or CFRA leave will cause substantial and grievous economic harm to us.

(Explain (a) and/or (b). See § 825.219 of the FMLA regulations.)

While on leave, you (will/will not) be required to furnish us with periodic reports every _____ *(indicate interval of periodic reports, as appropriate for the particular leave situation)* of your status and intent to return to work *(see § 825.309 of the FMLA regulations)*. 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/will not) be required to notify us at least two work days prior to the date you intend to report for work.

You (will/will not) be required to furnish recertification relating to a serious health condition. *(Explain below, if necessary, including the interval between certifications as prescribed in § 825.308 of the FMLA regulations.)*

EMPLOYER RESPONSE TO EMPLOYEE REQUEST FOR FAMILY AND/OR MEDICAL LEAVE (FMLA/CFRA) [NOT PREGNANCY DISABILITY LEAVE]

DATE:_____

TO: _____
(Employee's Name)

FROM: _____
(Name of appropriate employer representative)

SUBJECT: REQUEST FOR FAMILY/MEDICAL LEAVE

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

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

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

☐ a serious health condition affecting your [ ] spouse; [ ] child; [ ] parent/domestic partner; for which you are needed to provide care;

☐ a qualifying exigency arising out of the fact that your spouse, son, daughter, or parent is on active military duty as a member of the Armed Forces of the United States, or has been notified of an impending call to such active duty status, in support of a contingency operation; or

☐ caring for your child, spouse, parent or next of kin, who is a member of the Armed Forces of the United States, and who is undergoing medical treatment, recuperation, or therapy, is otherwise in outpatient status, or is otherwise on the temporary disability retired list, for an injury or illness incurred in the line of duty on active duty in the Armed Forces and that may render the member medically unfit to perform the duties of the member's office, grade, rank, or rating.

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

Except as explained below, under the FMLA/CFRA you have a right for up to 12 weeks of unpaid leave in a 12-month period for the first four reasons listed above, and a right for up to 26 weeks of unpaid leave in a 12-month period for the last reason listed above. Where leave for the last reason listed above is taken, whether by itself or in combination with other types of Family Care and Medical Leave (and/or pregnancy disability leave), the total leave taken may not exceed 26 weeks in length in a 12-month period, except in special circumstances as warranted by law; likewise, leave for the first four reasons listed above may exceed 12 weeks in a 12-month period only in special circumstances as warranted by law.

In addition, in a 12-month period you have the right to have your health benefits, if any, maintained (under the same conditions as if you continued to work) for up to 12 workweeks of leave for the first four

reasons listed above and for up to 26 workweeks of leave for the last reason listed above. In no event will more than 26 workweeks of continued benefits be provided in a 12-month period.

Moreover, you must be reinstated to the same or an equivalent job with the same pay, benefits, and terms and conditions of employment on your return from leave, if your entitlement to leave has not expired at the time of your return. If you do not return to work following the expiration of your right to leave for a reason other than (1) the continuation, recurrence, or onset of a serious health condition which would entitle you to FMLA leave or (2) other circumstances beyond your control, you may be required to reimburse us for our share of health insurance premiums paid on your behalf during your leave.

This is to inform you that (*circle appropriate information, explain where indicated*):

You are (eligible/not eligible) for leave under the FMLA and/or CFRA.
The requested leave (will/will not) be counted against your annual FMLA and/or CFRA leave entitlement as allowed by law.

You (will/will not) be required to furnish (medical certification of a serious health condition, medical certification of a serious illness or injury sustained by a member of the Armed Forces, or certification of a qualifying exigency). If required, you must furnish certification by _____ (*insert date*) (must be at least 15 days after you are notified of this requirement). If you do not provide the requested information by this date, we may delay the commencement of your leave until the certification is submitted.

You may elect to substitute accrued vacation or paid time off for unpaid FMLA/CFRA leave. We (will/will not) require that you substitute accrued vacation or paid time off for unpaid FMLA/CFRA leave. We (will/will not) require that you substitute sick time for unpaid FMLA/CFRA leave. If paid leave will be used, the following conditions will apply:

(Explain other conditions)

You currently have the following accrued vacation or paid time off benefits and sick leave benefits available (*list available vacation, paid time off, and sick time*).

(a) Health insurance benefits will continue during leave to the same extent and under the same conditions as if you were not on leave, but only for 12 workweeks within a 12-month period, unless you take leave to care for a family member recovering from a serious illness or injury sustained in the line of duty on active duty, in which case such continuation of health insurance benefits may be for up to 26 workweeks within a 12-month period to he extent that any continuation beyond 12 workweeks is in connection with leave to care for a family member recovering from a serious illness or injury sustained in the line of duty on active duty. Thus, if you normally pay a portion of the premiums for your health insurance, these payments must continue in order to continue your health insurance benefits during leave. Arrangements for payment have been discussed with you and it is agreed that you will make premium payments as follows:

(*Set forth dates, e.g., the 10th of each month, or pay periods, etc., that specifically cover the agreement with the employee.*)

You have a minimum 30-day (*or, indicate a longer period, if applicable*) grace period in which to make premium payments. If payment is not made timely, your group health insurance may be canceled, provided we notify you in writing at least 15 days before the date that your health coverage will lapse or, at your option, we may pay your share of the premiums during FMLA/CFRA 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.

We (will/will not) do the same with other benefits (*e.g.*, life insurance, disability insurance, etc.) while you are on FMLA/CFRA 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.
You (will/will not) be required to present a fitness-for-duty certificate prior to being restored to employment. If such certification is required but not received, your return to work may be delayed until the certification is provided.

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

We (have/have not) determined that restoring you to employment at the conclusion of FMLA and/or CFRA leave will cause substantial and grievous economic harm to us. (*Explain (a) and/or (b) below. See § 825.219 of the FMLA regulations.*)

While on leave, you (will/will not) be required to furnish us with periodic reports every _____ _____ (*indicate interval of periodic reports, as appropriate for the particular leave situation*) of your status and intent to return to work (*see § 825.309 of the FMLA regulations*). If the circumstances of your leave change and you are able to return to work earlier than the date indicated on the reverse side of this form, you (will/will not) be required to notify us at least two work days prior to the date you intend to report for work.

You (will/will not) be required to furnish recertification relating to a serious health condition. (*Explain below, if necessary, including the interval between certifications as prescribed in § 825.308 of the FMLA regulations.*)

CERTIFICATION OF HEALTH CARE PROVIDER SUPPORTING REQUEST FOR PREGNANCY LEAVE OR TRANSFER

TO BE COMPLETED BY HEALTH CARE PROVIDER

Employee's Name: _____

The Employee named above has made a request for a Pregnancy Disability Leave of absence or a transfer to a less strenuous or hazardous position or to less strenuous or hazardous duties. After reviewing Employee's job description (or interviewing Employee concerning her job if no job description is available) please examine Employee and determine the following:

1. If Employee is requesting a Pregnancy Disability Leave:

a. In your opinion, on what date will (or has) Employee become disabled by pregnancy? *(Disabled by pregnancy means that Employee is unable, because of her pregnancy, to work at all, or is unable to perform any one or more of the essential functions of her job or to perform these functions without undue risk to herself, the successful completion of her pregnancy, or to other persons. A woman is also considered to be disabled by pregnancy if she is suffering from severe "morning sickness" or needs to take time off for prenatal care.)* [NOTE: PLEASE DO NOT PROVIDE CONFIDENTIAL MEDICAL INFORMATION CONCERNING EMPLOYEE.]

_____

b. In your opinion, what will be the probable duration of the period or periods of disability?

_____

c. If it is foreseeable that Employee's condition will result in intermittent periods of disability, what will be the frequency of these periods and the probable duration of their occurrence?

_____

_____

_____

_____

2. If Employee is requesting a transfer to a less strenuous or hazardous position or to less strenuous or hazardous duties, please indicate the following:

a. The date on which the need to transfer became or will become medically advisable:

_____

b. The probable duration of the period or periods of the need to transfer:

_____

_____

c. Any explanatory statement that, due to the woman's pregnancy, the transfer is medically advisable including a description of the type or types of duties that should not be performed. [NOTE: PLEASE DO NOT PROVIDE CONFIDENTIAL MEDICAL INFORMATION CONCERNING EMPLOYEE.]

_____

_____

_____
Name of Health Care Provider

_____
Signature of Health Care Provider

_____
Date

REQUEST FOR LEAVE OF ABSENCE OR REDUCED WORK SCHEDULE FOR FAMILY/MEDICAL REASONS

EMPLOYEE'S NAME:_____

3. I request a leave of absence for the reason(s) specified below. I understand that my eligibility for this leave will be determined pursuant to Company policy and the relevant law.

Pregnancy Disability Leave:

☐ Leave/absences for severe morning sickness, prenatal care or disability due to pregnancy, childbirth or related medical conditions.

Medical Disability Leave:

☐ Leave/absences to care for my own serious health condition (other than pregnancy).

Workers' Compensation Leave:

☐ Leave/absences to care for my own work-related illness or injury.

Family Care Leave:

☐ Leave/absences to care for the serious health condition of my parent, child or spouse/registered domestic partner.

☐ Leave/absences to care for my newborn infant, or for placement with me of a child for adoption or foster care.

☐ Leave/absences because of a qualifying exigency arising out of the fact that my spouse, son, daughter, or parent is on active military duty as a member of the Armed Forces of the United States, or has been notified of an impending call to such active duty status, in support of a contingency operation.

☐ Leave/absences to care for my child, spouse, parent or next of kin who is a member of the Armed Forces of the United States and is undergoing medical treatment, recuperation, or therapy, is otherwise in outpatient status, or is otherwise on the temporary disability retired list, for an injury or illness incurred in the line of duty on active duty in the Armed Forces and that may render the member medically unfit to perform the duties of the member's office, grade, rank, or rating.

Military Leave:

☐ Leave/absence to fulfill my military obligations in a branch of the Armed Forces of the United States.

Leave for Military Spouses/Domestic Partners Only:

☐ Leave to be with my spouse/registered domestic partner during his or her leave from a military deployment.

School Activity Leave:

☐ Leave/absence to attend a school function of my child.

4. I request time off as follows:

(a) ☐ A leave of absence starting on _____ and continuing until _____

(b) ☐ Intermittent leave as described below:

_____

_____.

(c) ☐ A reduced work schedule from _____ hours/days per week to _____ hours/days per week from _____ until _____.

_____ _____

Employee Signature **Date**

TO BE COMPLETED BY SUPERVISOR

1. Is employee eligible for FMLA/CFRA leave?

☐ Employed at least one year;
☐ Worked more than 1,250 hours within last 12 months;
☐ Works at location with at least 50 employees within a 75-mile radius.

2. Has employee used FMLA/CFRA/PDL leave within past 12 months?

☐ Yes ☐ No

If Yes, how many days of leave have been taken during that period? _____

_____ _____

Supervisor's Signature Date

Please submit this form to Human Resources.

PHYSICIAN'S RELEASE TO RETURN TO WORK

Employee/Patient _____

Title/Position _____

I certify that the employee is able to resume performing the full functions of their job at **{company}** on _____/_____/_____.

I certify that the employee is able to return to work with the following restrictions:

Number of hours per day _____

Number of days per week _____

Other restrictions _____

_____
_____
_____
_____
_____
_____

Restrictions apply from ___/___/___ to ___/___/____.

Employee is released for full duties beginning: ___/___/___.

Date ___/___/___

Physician's signature _____

Print physician's name _____

Address _____

_____

Telephone _____

POLICY
Cemetery & Funeral Allowances
For Diocesan Clergy & Employees

- Allowances are available for facultied Diocesan clergy, and for actively working, full-time and part-time (not temporary) employees of the Diocese who have been employed for one (1) year or more.
- Religious Orders: Allowances may not apply for members of religious orders. Such arrangements are handled on a case-by-case basis subject to discretionary approval beforehand—i.e. prior to any arrangements being made or committed to by any party—by Catholic Funeral & Services director-level management (Management).
- Former Diocesan Employees
    - Former employees who have retired in good standing from the Diocese may be eligible for some allowance relating to their own burial arrangements, subject to discretionary approval beforehand by Management.
    - Former employees who resigned, or were otherwise released from employment, are not eligible.
- Allowances apply only to funeral and cremation services and products (collectively "Funeral Services") provided by Holy Angels Funeral and Cremation Services and only to cemetery burial rights, services and products (collectively "Cemetery Services") provided by Diocese of Oakland Catholic Cemeteries.
- Allowances have no cash value, and are non-transferable
- Burial rights to graves, crypts and niches (Burial Spaces) are subject to availability at each Catholic cemetery location.
- Discounts and prices are subject to change without notice.
- Employees married to each other may only purchase jointly, not separately
- Cathedral of Christ the Light Mausoleum: the allowances below may apply, however all allowances relating to interments in the Cathedral Mausoleum are subject to Management's discretionary approval beforehand.
- Other discounts or allowances—such as promotional discounts or special consideration allowances—do not apply in addition to or in conjunction with this policy.

Priests

***Funeral**:* Free Holy Angels Funeral Services, $2,600 allocation for Holy Angels-provided casket.

***Cemetery*:** Free grave and no service charges. Value of grave (up to a maximum of $5,000) can be applied to crypt or more expensive Burial Space.

Deacon and Spouse

Funeral At-need or Pre-need: 50% off all charges including Holy Angels-provided casket or urn for both Deacon and his spouse (for married Deacons this amounts to one full funeral service at no charge)

Cemetery At-need or Pre-need: One free grave (one single or one double-space only) and no service charges. Value of grave (up to a maximum of $5,000) can be applied to a more expensive Burial Space.

Diocesan Employees & Employees of Catholic Elementary and Secondary Schools Listed in the Official Directory of the Diocese of Oakland

Funeral At-need or Pre-need: 25% off all funeral plans including Holy Angels-provided casket for employee and employee's immediate family (spouse, children and parents only). In the case of an employee's extended family (siblings, grandchildren and grandparents only), a 10% discount may be granted provided the employee is taking care of the arrangements as the financially-responsible party (requires discretionary approval by Management beforehand).

Cemetery At-need or Pre-need: 25% off Burial Space, full charges for other services, for employee and employee's immediate family (spouse, children and parents only). In the case of an employee's extended family (siblings, grandchildren and grandparents only), a 10% discount may be granted provided the employee is taking care of the arrangements as the financially-responsible party (requires discretionary approval by Management beforehand).

Financing

At-need Funeral Services and At-need Cemetery Services need to be paid in full at the time of service.

Pre-need Services may be financed at 0% interest for up to five years via employee payroll deduction.

Contact Information

For additional information contact Catholic Funeral and Cemetery Services at (925) 946-1440.