

**UNION COUNTY
PERSONNEL POLICY MANUAL**

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**UNION COUNTY
PERSONNEL POLICY MANUAL**

ACKNOWLEDGMENT

FORM A

Employee Name (print): _____

It is the responsibility of each individual employee to review and become familiar with the contents of the Union County Personnel Policy Manual. I hereby acknowledge that I have read (or had read to me) this document. I hereby acknowledge that I understand and agree to comply with all of the policies and procedures contained therein.

I further understand that this manual is not considered an employment contract and that changes may occur to this manual. I agree to comply with all change to the policies and procedures contained in the Personnel Policy Manual.

By placing my signature below, I understand and acknowledge that I am aware of my responsibilities as outlined above. I am aware that I may access this manual online at www.unioncountyohio.gov. I am also aware that the Personnel Manual contains policies regarding Unlawful Harassment and/or Discrimination, Alcohol Misuse and Drug Abuse in the Workplace, Workplace Violence, Safety, and other important issues that I must become familiar with.

Employee Signature: _____

Date: _____

**UNION COUNTY
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APPLICATION FOR EMPLOYMENT

**FORM B
PAGE 1 OF 5**

**UNION COUNTY
APPLICATION FOR EMPLOYMENT**

Union County, Ohio is an equal opportunity employer. Union County, Ohio does not deny equal opportunity in hiring, tenure, terms, conditions or privileges of employment on the basis of race, color, religion, sex, national origin, disability, ancestry, age, sexual orientation, or other legally protected status.

Please type or print responses to the questions and information requested below. Note that this completed application for employment will become a public record upon submission to Union County and subject to disclosure under Ohio Public Records Law. Please note, if offered employment, you may be subject to a medical physical, drug/alcohol screen, Bureau of Motor Vehicle license check and/or fingerprint background check.

POSITION APPLYING FOR: _____

PERSONAL INFORMATION: _____

NAME: _____
(Last) (First) (Middle)

ADDRESS: _____
(Number) (Street) (City) (State) (Zip)

PRIMARY TELEPHONE NUMBER: _____

OTHER TELEPHONE NUMBER: _____ EMAIL: _____

APPLICANT QUESTIONS:

1. Are you legally eligible to work in the United States of America? ☐ Yes ☐ No
2. Are you currently or have you ever been employed by Union County? ☐ Yes ☐ No
 - a. If yes, what office/department? _____
3. Do you have any relatives employed by Union County? ☐ Yes ☐ No
 - a. If yes, please list name, relationship, and office/department: _____
4. Have you ever been involuntarily terminated or asked to resign from employment: ☐ Yes ☐ No
 - a. If yes, please explain: _____
5. Desired Start Date: _____
6. Desired Salary or Hourly Rate: _____
7. Are you currently employed? ☐ Yes ☐ No
 - a. If employed, may we contact your present employer? ☐ Yes ☐ No
 - b. If we cannot contact your present employer, please explain: _____

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APPLICATION FOR EMPLOYMENT

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EDUCATION: List the following information:

School	Name of Institution	City/State	Did you graduate? Yes or No	Degree Earned or Course of Study
High School Or GED			<input type="checkbox"/> Yes <input type="checkbox"/> No	
College			<input type="checkbox"/> Yes <input type="checkbox"/> No	
Graduate School			<input type="checkbox"/> Yes <input type="checkbox"/> No	
Other			<input type="checkbox"/> Yes <input type="checkbox"/> No	

JOB SPECIFIC CERTIFICATIONS OR LICENSES:

TITLE: _____

_____ ISSUED BY _____

DATE ISSUED _____ EXPIRATION DATE _____

DRIVER'S LICENSE:

Do you possess a valid state Driver's License? ☐ Yes ☐ No

State of Issuance: _____ License # _____

License Class (A, B, C): _____

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EMPLOYMENT INFORMATION: Please indicate your work experience, beginning with the most recent employment, and be specific in your description of job duties. Include **all** relevant work experience, volunteer work and military service, if applicable. Attach additional sheets if necessary or resume.

Name of Employer_____

Address of Employer_____

Supervisor's Name and Title:_____ Supervisor's Phone Number:_____

Start Date:_____ End Date:_____

Job Title:_____ Salary:_____ Reason for Leaving:_____

Job Duties:_____

Name of Employer_____

Address of Employer_____

Supervisor's Name and Title:_____ Supervisor's Phone Number:_____

Start Date:_____ End Date:_____

Job Title:_____ Salary:_____ Reason for Leaving:_____

Job Duties:_____

Name of Employer_____

Address of Employer_____

Supervisor's Name and Title:_____ Supervisor's Phone Number:_____

Start Date:_____ End Date:_____

Job Title:_____ Salary:_____ Reason for Leaving:_____

Job Duties:_____

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APPLICATION FOR EMPLOYMENT

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PROFESSIONAL REFERENCES: Please indicate three (3) persons, not related to you, who can be contacted regarding your work or academic performance.

Name: _____ Title: _____

Email: _____ Contact Number: _____

Name: _____ Title: _____

Email: _____ Contact Number: _____

Name: _____ Title: _____

Email: _____ Contact Number: _____

CERTIFICATION OF APPLICATION:

By signing this application, I hereby certify that every statement I have made in this application is true and complete to the best of my knowledge. I understand that any false or incomplete answer may be grounds for not employing me or for dismissing me after I begin work. I understand that I will have to produce documentation verifying identity and employment eligibility in the United States. I understand that I may be required to verify any and all information given on this application. I understand that this completed application is the property of the Union County and will not be returned. I understand that my application is subject to disclosure pursuant to the Ohio Public Records Act. I understand that Union County may contact prior employers and other references. I understand that I must notify Union County of any changes in my name, address, phone number, or email address. I understand that communications with Union County may be sent via email.

I voluntarily and knowingly authorize Union County to verify the information contained in my employment application. I authorize any third party organization to perform a consumer report and background investigation. I also authorize and consent any employers, schools or persons listed on this application (or accompanying resume) to provide information regarding my employment, qualifications and character to Union County (including but not limited to performance evaluation and reports, job descriptions, disciplinary reports, letters of reprimand, and opinions regarding my suitability for employment). I understand that I may be required to take a drug test, as a condition of employment or at any time during employment. I voluntarily and knowingly, fully release and discharge, absolve, indemnify and hold harmless you, your agents and any former employer, person, firm, corporation, school or government agency, its officers, employees and agents from any and all claims, liability, demands, causes of action, damages, or costs, including attorney's fees, present or future, whether known or unknown, anticipated or unanticipated, arising from or incident to the disclosure or release of any such information to you, your agents, or consumer reporting agency.

READ CAREFULLY BEFORE SIGNING: I agree that any claim or lawsuit relating to my service with Union County 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. I have read and understand the contents of this employment application and am fully able and competent to complete it.

Signature: _____

Date: _____

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PERSONNEL POLICY MANUAL**

APPLICATION FOR EMPLOYMENT

**FORM B
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**Union County
Record-Maintenance Form**

The Federal Guidelines on Employee Selection (1978) require employers to maintain and have available for inspection, records or other information which will disclose the impact which the employer's test and other selection procedures have upon employment opportunities of person by identifiable race, gender, and ethnic group. Compliance with this mandate requires that each applicant be requested to complete the following questions relating to gender and race. Your responses to the questions relating to gender and race are voluntary.

Information concerning your knowledge that a position was available will assist us in our recruitment efforts. Thank you for your cooperation.

1. Position applied for: _____

2. Gender: (Please check one)

☐ Male ☐ Female ☐ Do Not Care to Respond

3. Race (please check the category that applies to you)

☐ White/Caucasian
☐ Black/African-American
☐ American Indian (including Alaskan Natives)
☐ Asian (including Pacific Islanders)
☐ Hispanic (including persons of Mexican, Puerto Rican, Cuban, Central or South American origin or culture, regardless of race)
☐ Other (specify) _____
☐ Do Not Care to Respond

4. Are you a veteran of the armed forces?

☐ Yes ☐ No ☐ Do Not Care to Respond

5. How did you hear about this position?

☐ Job Posting
☐ Word of Mouth
☐ Union County Website
☐ Bulletin Board (please specify where): _____
☐ Newspaper (please specify): _____
☐ Internet (please specify): _____
☐ Other (please specify): _____

**UNION COUNTY
PERSONNEL POLICY MANUAL**

CONDITIONAL FULL-TIME OFFER LETTER

FORM C

LETTERHEAD

Name: _____

Address: _____

Date: _____

Welcome to employment with Union County. You are being appointed to the position of _____, effective _____, 20____.

(name of position) (date)

This is a full-time _____(classified/unclassified), _____(exempt/non-exempt) position supporting the _____ Department/Office, and the typical work hours are _____. [If unclassified: You shall serve in this position at the pleasure of the appointing authority and may be terminated from employment with or without cause, with or without notice, with no right of appeal.] Your starting pay rate will be _____ per _____.

As a full-time employee, you will be eligible for a wide range of benefits, including participation in the County's medical, dental, vision, and life insurance programs. These benefits will be reviewed with you in detail upon hire and will become effective on the first day of the month following your start date. In addition, you will be enrolled in the Ohio Public Employees Retirement System.

Your employment is subject to passing a pre-employment background investigation. All pre-employment services will be at no cost to you. Upon acceptance of this employment offer we will provide you with additional information and assistance in satisfying the pre-employment requirements.

If you are unable to satisfy the above conditions, this offer of employment will be withdrawn. Please be aware that this letter does not constitute a guarantee or contract of employment. Accordingly, you or the employer may terminate the selection process at any time for any reason.

Please contact me if you have any questions concerning your appointment.

Appointing Authority

Date

Department Head/Director

Date

I hereby acknowledge and accept appointment to the unclassified service as provided herein.

Employee signature

Date

Appointment approved by Union County Board of Commissioners on _____, by resolution number _____. (date)

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TEMPORARY APPOINTMENT LETTER

FORM D

LETTERHEAD

Name: _____

Address: _____

Date: _____

Welcome to employment with Union County. You are being appointed to the position of _____, effective _____, 20____.
(name of position) (date)

This is a temporary appointment for one specified period of time not to exceed 120 days. During this period, you shall be scheduled (day)_____ through (day)_____, from _____ .m. to _____ .m.
(time) (time)

Any change in your work schedule will be communicated to you.

As a temporary appointment, this position is in the unclassified service. You shall serve in this position at the pleasure of the appointing authority, and may be terminated from employment with or without cause, with or without notice, with no right of appeal.

Please contact me if you have any questions concerning your appointment.

Appointing Authority

Date

Department Head/Director

Date

I hereby acknowledge and accept appointment to the unclassified service as provided herein.

Employee signature

Date

Appointment approved by Union County Board of Commissioners on _____, by resolution number _____.
(date)

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INTERMITTENT APPOINTMENT LETTER

FORM E

LETTERHEAD

Name: _____

Address: _____

Date: _____

Welcome to employment with Union County. You are being appointed to the position of _____, effective _____, 20____.

(Name of position) (date)

This is an intermittent appointment. You will be required to work an irregular schedule which will be determined by the fluctuating demands of the work and is not predictable.

Your actual work hours will be determined on a daily basis depending on the need for your services which will fluctuate.

As an intermittent appointment, this position is in the unclassified service. You shall serve in this position at the pleasure of the appointing authority, and may be terminated from employment with or without cause, with or without notice, with no right of appeal.

Please contact me if you have any questions concerning your appointment.

Appointing authority

Date

Department head/Director

Date

I hereby acknowledge and accept appointment to the untested, non-tenured classified service as provided herein.

Employee signature

Date

Appointment approved by Union County Board of Commissioners on _____, by resolution number _____. (date)

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REEMPLOYMENT OF RETIREE

FORM F

Employee Name (print): _____

I have received and read the County's Reemployment of a Retiree policy. I understand that I am considered a reemployed retiree and that the benefits of my employment are described in this policy. As such, I acknowledge that for purposes of computing vacation leave, my prior public sector service will not count as credit toward my Union County vacation accruals. In addition, I also understand that upon my future separation from employment from Union County, I will not be eligible to be paid out for any unused, accumulated sick leave. I hereby acknowledge that I understand this policy in its entirety and agree to comply with this policy.

Employee Signature: _____

Date: _____

Witness Signature: _____

Date: _____

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UNCLASSIFIED SERVICE ACKNOWLEDGMENT

FORM G

Employee Name _____

Date: _____

Subject: Unclassified Status

Dear _____:

The position that you are being offered in the Union County _____ is exempt from Civil Service protection, per section 124.11 _____ of the Ohio Administrative Code. This section is reserved for _____

The unclassified exemption means that civil service protection is not available to you, that you work at the pleasure of the Union County _____ and may be dismissed without cause as an “at-will” employee.

Attached to this letter is the job description that qualifies this position for unclassified status. If you understand and accept the terms of your appointment to this position and status, please sign the acceptance statement below.

Very Sincerely,

I understand and accept the terms of my appointment to this office, and my employment by _____. I also understand that by voluntarily and knowingly accepting this position, I give up any protection that I might have had if I was a classified employee in the Union County _____ prior to accepting this position.

Employee Signature

Date

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EMERGENCY CONTACT INFORMATION

**FORM H
PAGE 1 OF 1**

Employee Name: _____

(Please print)

Check one, sign and date, and complete the form as indicated

- ☐ I voluntarily provide the requested information, which will be given to healthcare professionals in the event of an emergency situation resulting in the need for medical care
- ☐ I do not wish to provide the requested information

Employee Signature

Date

Primary Care Physician: _____

Phone: _____

Person(s) to notify in case of accident or emergency medical condition:

1st contact: Name: _____ Relationship: _____

Phone: _____ Phone: _____
(most likely to be reached at) (alternate number)

2nd contact: Name: _____ Relationship: _____

Phone: _____ Phone: _____
(most likely to be reached at) (alternate number)

****This sheet will be secured by Human Resources and maintained in a confidential manner and will be used solely for emergency medical treatment/notification purposes.****

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EXIT INTERVIEW

**FORM I
PAGE 1 OF 2**

TO BE COMPLETED BY EMPLOYEE

Name: _____ Department: _____

Job title: _____ Separation date: _____

Current mailing address: _____

Reason for termination: _____

EMPLOYEE'S EVALUATION OF THE JOB

	Excellent	Satisfactory	Fair	Poor	Unsatisfactory
Interest in 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 and management					
General working conditions					

Employee's comments: _____

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EXIT INTERVIEW

**FORM I
PAGE 2 OF 2**

TO BE COMPLETED BY SUPERVISOR

Interviewer: _____ Date: _____

Employee's comments: _____

Supervisor/Appointing Authority Signature

Date

**UNION COUNTY
PERSONNEL POLICY MANUAL**

REQUEST FOR OVERTIME APPROVAL

FORM J

Employee name: _____

Employee classification: _____ Department: _____

Date of overtime: _____ Number of overtime hours: _____

Reason for overtime: _____

Employee signature

Date

Method of Compensation: ☐ Cash payment ☐ Compensatory time

ADMINISTRATIVE ACTION

☐ Approved ☐ Disapproved

Department Head/Supervisor

Date

NOTE: This form should be completed in advance of any overtime to be worked.

FORM K

**UNION COUNTY
PERSONNEL POLICY MANUAL**

REQUEST FOR LEAVE OF ABSENCE

FORM L

Employee name: _____ Date: _____

Leave requested: ☐ Sick ☐ Funeral ☐ Vacation ☐ Court
☐ Military Leave ☐ Military, Long-Term ☐ Comp Time ☐ FMLA
☐ Disability Leave ☐ Disability Separation ☐ Unpaid Leave

Reason for leave: _____

(Attach a copy of the subpoena, court order, military order, obituary, or physician's statement verifying the reason for leave.)

Beginning date/time of leave: _____ Ending date/time of leave: _____

TOTAL HOURS: _____

SICK LEAVE ONLY (give details of reason for sick leave usage):

☐ Medical/dental/optical appointment of employee (date & time): _____

☐ Illness of employee (state exact nature of illness): _____

☐ Injury of employee (state exact nature of injury): _____

☐ Medical appointment of family member (please state date & time of appointment and why your attendance was necessary):

☐ Illness or injury of family member (please state nature of illness or injury and why your attendance was necessary):

☐ Death of family member (state name & relationship of deceased): _____

_____ Date of death: _____ Date of funeral: _____

NUMBER OF HOURS OF SICK LEAVE REQUESTED (in 15 min. increments): _____

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

Employee Signature

ADMINISTRATIVE ACTION:

Supervisor: ☐ Approved ☐ Not approved (Signature) _____

Department head: ☐ Approved ☐ Not approved (Signature) _____

Appointing authority: ☐ Approved ☐ Not approved (Signature) _____

UNION COUNTY
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FAMILY AND MEDICAL LEAVE FORMS

FORM M

EMPLOYEE FMLA REQUEST FORM

TO BE COMPLETED BY EMPLOYEE:

Name: _____

Title: _____ Division/Department: _____

Home/Cell Phone: _____ Preferred Email: _____

Home Mailing Address: _____

Date Of Birth/Adoption (If Applicable): _____

If For A Family Member, State Their Name And Your Relationship To Them: _____

The Basis For The FMLA Request Is:

- ☐ Birth of child, and/or care of newborn, adopted or foster care child
- ☐ Care of a qualifying family member with Serious Health Condition
- ☐ Employee's own Serious Health Condition
- ☐ Military-Related Leave

I seek # of _____ days or _____ weeks
_____ in a block of time or _____ intermittently,

Please use: ☐ Sick time first, then vacation, then unpaid leave
 ☐ Vacation first, then sick time, then unpaid leave
 ☐ Unpaid leave
 ☐ Other _____

Employee Signature

Date

TO BE COMPLETED BY HUMAN RESOURCES

HR Director

Date Received

Date Sent to Supervisor

- ☐ Employee has worked for the 12 prior months
- ☐ Employee has met the 1,250-hours-worked requirement
- ☐ Employee has not used up his or her yearly FMLA leave entitlement

Other comments, if any: _____

Additional FMLA forms are available at:

<https://www.dol.gov/agencies/whd/fmla/forms>

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APPLICATION TO RECEIVE DONATED LEAVE

FORM N

Employee's name: _____ Employer: _____

Please describe the catastrophic illness/injury, who is affected, and how the employee is affected:

Indicate the amount of time that will be missed because of the catastrophic illness/injury:

Number of days: _____ Beginning: _____ Ending: _____

Has the employee exhausted all paid leave, completed his or her new-hire probationary period, applied for Workers' Compensation and/or disability retirement (if eligible), applied for FML?

☐ Yes ☐ No

Does the employee have a patterned use of sick leave? ☐ Yes ☐ No

VERIFICATION BY ATTENDING MEDICAL DOCTOR

I certify that the above named individual has experienced a catastrophic illness and/or injury and the projected time missed is an accurate forecast of the time that is needed for the condition.

Doctor's name: _____

Doctor's signature: _____ Date: _____

I verify that the above information is a true and accurate report of my condition as I know today. I authorize and approve distribution of this information to other Union County employees to inform them of my condition and to permit other county employees to donate sick leave and/or vacation to me. I understand and agree that my appointing authority will make notice of my need for leave and that I should take no other action to solicit or request donation of leave from other staff. I have read, understand, and agree with the limitations of this program as outlined in the *Leave Donation Policy*. I understand and agree that any leave taken under this program will be included and is subject to the 12 week limits of the Family and Medical Leave Act. I understand and agree that any employee donating leave to me will have his or her identity kept confidential from me.

Witness's signature

Date

Employee's signature

Date

This application has been reviewed and **APPROVED/DENIED** (Circle One).

Name of reviewer

Signature

Date

**UNION COUNTY
PERSONNEL POLICY MANUAL**

APPLICATION TO DONATE LEAVE

FORM O

Donator's (transferor) name: _____ Employer: _____

Receiver's (transferee) name: _____ Employer: _____

Type of leave: ☐ Sick Leave ☐ Vacation Leave (Check one or both)

Hours of sick leave to be donated – must be in one (1) donor day increments up to a maximum of 15 days (120 hours) equivalence: _____

Balance of sick leave after donation: _____

Hours of vacation to be donated – must be in one (1) donor day increments: _____
(no limit)

I hereby certify that this request is made voluntarily. I was not coerced, intimidated, or financially induced into donating leave. By signing, I hereby relinquish all rights to the leave shown above and the benefits accrued to or attached to the same. I understand and agree that the donation of the leave is irrevocable and that no leave actually donated will be refunded to me. I certify that I will have at least 480 hours of sick leave after making this donation.

Witness's signature

Date

Transferor's (donator) signature

Date

CERTIFICATION:

____ Sick leave balance above is certified as correct
____ Sick Leave balance above is certified as incorrect
____ Balance of sick leave

____ Vacation balance above is certified as correct
____ Vacation balance above is certified as incorrect
____ Balance of vacation

Signature of Union County Auditor or Designee

Date

Printed name:

Title:

Sick Leave Donation: ☐ **APPROVED** ☐ **DENIED**

Signature of Appointing Authority

Date

Union County Auditor or Designee

Date

**UNION COUNTY
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WORKERS' COMPENSATION REIMBURSEMENT

FORM P

**Agreement covering compensation reimbursement during the period
claim is pending before the Industrial Commission of Ohio**

It is mutually agreed by and between the employer, _____,
and the claimant, _____, who was injured on
_____, 20____, while in the course of and arising out of his employment
with the employer named herein, that since such employer has or will advance to the claimant his
regular wages, or part thereof, for the period of _____,
claimant authorizes the Industrial Commission of Ohio and/or the Bureau of Workers'
Compensation to mail his warrants for temporary total compensation in care of the employer.

The claimant also agrees to endorse such warrants received from the Industrial Commission of
Ohio in favor of the employer, in order that said employer may be reimbursed to the extent of the
advancements made to claimant, or any portion thereof as agreed upon.

Employer

Claimant

**UNION COUNTY
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**NOTICE TO EMPLOYEES REGARDING THE DRUG FREE
WORKPLACE ACT POLICY**

FORM Q

Union County supports the Drug Free Workplace Act of 1988 (PL-100-690). Consequently, any unlawful manufacture, distribution, dispensation, possession, or use of controlled substances on these premises by employees is strictly prohibited and violators will be subject to discipline and criminal prosecution.

This policy is to be regarded as a condition of employment and any employee convicted of a work-related drug offense must notify the board of commissioners no later than five (5) calendar days after conviction.

NOTATION: We recommend this notice be reproduced and posted in a public place.

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CERTIFICATION OF DRUG FREE WORKPLACE COMPLIANCE

FORM R

Grantee: Union County

Fund Source: _____ Date: _____
(address)

A. The grantee hereby certifies that it will provide a drug free workplace by:

1. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession, or use of a controlled substance is prohibited in the grantee's workplace and specifying the action that will be taken against employees for violation of such prohibition.
2. Establishing a drug free awareness program to inform employees about:
 - a. The dangers of drug abuse in the workplace.
 - b. The grantee's policy on maintaining a drug free workplace.
 - c. Any available drug counseling, rehabilitation, and employee assistance programs/
 - d. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace.
3. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (1).
4. Notifying the employee in the statement required by paragraph (1) that, as a condition of employment under the grant, the employee will:
 - a. Abide by the terms of the statement.
 - b. Notify the Employer of any criminal drug statute conviction for a violation occurring in the workplace no later than five days after such conviction.
5. Notifying the agency within ten days after receiving notice under subparagraph (4)(b) from an employee or otherwise receiving actual notice of such conviction.
6. Taking one of the following actions, within thirty days of receiving notice under subparagraph (4)(b), with respect to any employee who is so convicted:
 - a. Taking appropriate personnel action against such an employee, up to and including termination.
 - b. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a

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CERTIFICATION OF DRUG FREE WORKPLACE COMPLIANCE

FORM R

federal, state, or local health, law enforcement, or other appropriate agency.

7. Making a good faith effort to continue to maintain a drug free workplace through implementation of paragraphs (1), (2), (3), (4), (5), and (6).

- B. The grantee shall insert in the space provided below the site(s) for the performance of work done in connection with the specific grant:

Place of performance (street address, city, county, state, zip code).

I hereby acknowledge receipt of the "Union County's Drug Free Workplace Policy" on the date indicated below. I further acknowledge that I understand and support this drug free workplace policy, and I agree to refrain from violating this policy while in the employ of Union County. I hereby acknowledge that I have received and read a copy of my employer's policy and procedures on a drug free workplace, which establishes my obligations as an employee. I further understand that if I breach this policy or acknowledgment, I could be subject to criminal prosecution and/or discipline including termination of my employment.

Recipient

Date

Witness

**UNION COUNTY
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DRUG TESTING WAIVER AND CONSENT

FORM S

I, _____, hereby agree, upon a request made under the drug/alcohol testing policy of Union County, to furnish a sample of my urine or breath for analysis. I understand and agree that if I at any time refuse to submit to a drug or alcohol test under the policy, or if I otherwise fail to cooperate with the testing procedures, I will be subject to discipline up to and including termination. I further authorize and give full permission to have the county and/or its physician send the specimen or specimens so collected to a laboratory for a screening test for the presence of any prohibited substances under the policy, and for the laboratory or other testing facility to release the results of such test to the county, its supervisors, its administrators, its advisors, and other persons with an administrative need to know, and/or to any other governmental entity involved in a legal proceeding or investigation connected with the test with an administrative need to know to the extent not prohibited by law.

I have received a copy of the Drug Free Workplace Policy and Drug Testing Policy and it has been explained to me in a language I understand, and I have been told that if I have any questions about the test or the policy, they shall be directed to the human resources director.

Signature of employee

Date

Employee name (*print*)

Signature of employer representative

Date

**UNION COUNTY
PERSONNEL POLICY MANUAL**

**AGREEMENT OF RESPONSIBILITY: INTERNET, E-MAIL, AND
ONLINE SERVICE USE**

FORM T

(Department Name)

Access to the Internet, electronic mail, and online services has been granted to me as a privilege, for performing job duties and responsibilities for my department. I have read and agree to abide by the *"Union County Internet, Electronic Mail, and Online Service Use Policy"* and the following departmental terms and conditions which govern my use of these services.

Additional Department Terms and Conditions

Union County encourages employees to develop Internet, electronic mail, and online services knowledge. To help improve the effectiveness of the use of these resources, incidental and occasional personal use may be permitted as long as such use does not:

1. Interfere with existing department rules or policies
2. Disrupt or distract the conduct of county business (e.g., due to volume or frequency)
3. Involve solicitation
4. Involve a for-profit personal business activity on County time
5. Have the potential to harm the county
6. Involve illegal activities
7. Transmit/receive threatening, obscene, or harassing materials or correspondence
8. Have a cost associated with the use
9. Violate the usage guidelines previously mentioned in throughout document

By signing this *"Agreement of Responsibility,"* I certify that I understand and accept responsibility for adhering to the policies, procedures, and additional agency terms and conditions listed above and in the *Internet, Electronic Mail, and Online Services Use Policy* document. I also acknowledge my understanding that any infractions on my part may result in disciplinary action including, but not limited to, termination of my access privileges.

Employee name (*print*):_____

Employee signature

Date

Supervisor name (*print*):_____

Supervisor signature

Date

**UNION COUNTY
PERSONNEL POLICY MANUAL**

MOBILE DEVICE ACKNOWLEDGMENT

FORM U

I, _____ understand that I have been chosen to receive a Union County mobile device (e.g., mobile phone, tablet, laptop, etc.). I have read and understand the Union County *Use of Mobile Devices Policy*. As such, I also understand that I may be accountable for any and all charges incurred above and beyond the contractual monthly limits of the mobile device plan.

I understand that I may be accountable for any of the following additional charges for my mobile device:

1. Lost, stolen, or damaged mobile device equipment
2. Exceeding the amount of peak minutes allowed under the mobile device plan
3. Exceeding the amount of off-peak minutes allowed under the mobile device plan
4. Any roaming charges
5. Long distance charges
6. Web usage and download fees
7. Any other charges above and beyond the regular monthly service charge established by the mobile device plan.
8. And such other charges as may be deemed payable

**** You have no reasonable expectation of privacy in the use of a County owned mobile device****

Employee signature

Date signed

I, _____, received the following mobile device equipment. Furthermore, I understand that the following equipment must be returned at the request of the county of Union and/or on the date my employment ends with the county.

Phone/Laptop/Tablet/etc.: _____

Wall charger: ☐ Yes ☐ No

Car charger: ☐ Yes ☐ No

Additional equipment: ☐ Yes ☐ No

Employee signature

Date

**UNION COUNTY
PERSONNEL POLICY MANUAL**

SOCIAL MEDIA ACKNOWLEDGMENT

FORM V

I, _____, have received and read the *Social Media Policy*. I understand that the employer may monitor my compliance with the policy. I further understand that monitoring can extend beyond Employer-provided equipment and my time at work. I understand that I am required to abide by the policy and may be subject to discipline up to and including termination for violations. I realize any question concerning my conduct or use of such website should be addressed to my immediate supervisor.

Employee signature

Date

**UNION COUNTY
PERSONNEL POLICY MANUAL**

VEHICLE USE ACKNOWLEDGMENT

FORM W

Employee Name (print): _____

I hereby acknowledge that I have received and read a copy of my Employer's policy and procedures on use of *Employer-Owned/Leased Vehicles*, which establishes my obligations as an employee. By my signature below, I hereby acknowledge that I understand this policy, and agree to support and comply with its terms and conditions. I further understand that if I breach this policy or acknowledgement, I could be subject to discipline including termination of my employment.

Employee Signature: _____

Date: _____

**UNION COUNTY
PERSONNEL POLICY MANUAL**

**DRIVING RECORD INFORMATION, DISCLOSURE AND
AUTHORIZATION**

**FORM X
PAGE 1 OF 2**

DRIVING RECORD INFORMATION, DISCLOSURE AND AUTHORIZATION FORM

The information listed below and on the back of this form is needed by the County Risk Manager/Loss Control Coordinator to conduct new hire as well as periodic, ongoing driving record checks through Safety Holdings, Inc. (dba SambaSafety). Safety Holdings is the consumer reporting agency who CORSA has contracted with to provide these investigative driving reports. The below driver's license and insurance information must be provided upon hire and at least annually thereafter, as stated in the Union County Use of Vehicles Policy (Personnel Policy Manual, Section 7.06), and as outlined in the County's comprehensive property and casualty insurance plan documents.

Instructions: Review this information in its entirety, complete the requested information on the front and back, and return to the Board of Commissioners' Office, Attn: Human Resources. **Please provide your name EXACTLY AS IT IS PRINTED ON THE DRIVER'S LICENSE.**

Name (print): _____

Office / Department: _____

Date of Birth: _____

Driver's License Number: _____

License, Insurance, and Vehicle Maintenance Requirements

I, the undersigned, agree, as a requirement for driving a county-owned vehicle or personal vehicle during the course of employment, will maintain a valid State of Ohio Drivers' License. I also understand that a Motor Vehicle Report will be obtained by the Board of Commissioners' Office to confirm a valid Ohio Driver's License. I also agree, as a requirement for using my personal vehicle during the course of my employment with Union County, that I will retain automobile liability insurance for bodily injury and property damage on the vehicle that I am driving for at least the minimums required by the State of Ohio. I further agree to maintain my vehicle in, to the best of my knowledge, a roadworthy condition.

Signature: _____

Date: _____

Reminder: *Any official and/or employee who is authorized to use a county-owned or leased vehicle and whose operator's license is suspended, must notify their immediate supervisor of this fact as soon as possible. An Elected Official, department head, or supervisor must then notify the Board of County Commissioners. Refer to the complete Use of County-Owned Vehicles policy for additional rules and guidance.*

**UNION COUNTY
PERSONNEL POLICY MANUAL**

**DRIVING RECORD INFORMATION, DISCLOSURE AND
AUTHORIZATION**

**FORM X
PAGE 2 OF 2**

**DISCLOSURE AND AUTHORIZATION
TO OBTAIN DRIVING RECORDS
FOR EMPLOYMENT PURPOSES**

Please Read Carefully Before Signing this Authorization

DISCLOSURE

Union County or its affiliates ("the County") may request driving records through Safety Holdings, Inc. (dba SambaSafety). SambaSafety can be contacted by mail at 8814 Horizon Blvd #100, Albuquerque, NM 87113; or phone: (888) 947-2622; or website: www.sambasafety.com. Under the Fair Credit Reporting Act (FCRA), driving records are included in the definition of consumer reports because they are information collected by a consumer reporting agency bearing on matters including your character, general reputation, personal characteristics, or mode of living which is used or expected to be used or collected for the purpose of serving as a factor in making an employment-related decision about you.

Safety Holdings, Inc. is the consumer reporting agency who CORSA has contracted with to provide these investigative driving reports. **Union County WILL ONLY use the authorization and release form to obtain driving records from SambaSafety, the consumer reporting agency CORSA has retained. NO INQUIRIES whatsoever will be made into an individual's credit history. SambaSafety ONLY provides consumer reports relating to driving privileges.**

AUTHORIZATION

By signing below,

- I agree that have read and understand the foregoing Disclosure; and
- I authorize the County to obtain driver's license record checks about me for employment purposes; and,
- If I am hired or I have already been hired, I authorize the County to obtain additional driving record checks about me for employment purposes, from time to time while I am employed with the County, without further authorization from me.
- I further authorize the County to share the information in the driving record checks with any person involved in the employment decision about me.
- I understand that this authorization will only remain valid through my active employment with the County and that the County's authority to use/rely on this authorization will cease when my employment ends.

Name (print): _____

Signature: _____

Date: _____

Please refer to the enclosed information to read about your federal rights under the Fair Credit Reporting Act.

**UNION COUNTY
PERSONNEL POLICY MANUAL**

DISCRIMINATORY HARASSMENT ACKNOWLEDGEMENT

FORM Y

Employee Name (print): _____

I have received and read the County's Discriminatory Harassment policy. I understand that it is the policy of Union County to maintain an environment free from all forms of discrimination and harassment. I understand my rights and responsibilities as outlined in this policy. As such, I acknowledge that any employee who believes that he or she has been the subject of discriminatory harassment, and/or any employee who has witnessed an incident, or incidents, of discriminatory harassment, shall report the matter to the proper appointing authority or designee immediately. There will be no reprisals against any employee for making a report as outlined in this policy. I hereby acknowledge that I understand and agree to comply with this policy.

Employee Signature: _____

Date: _____

**UNION COUNTY
PERSONNEL POLICY MANUAL**

EEO/ADA/DISCRIMINATORY HARASSMENT COMPLAINT FORM

**FORM Z
PAGE 1 OF 2**

Individuals who feel they have been discriminated against on the basis of race, color, religion, sex, national origin, age, disability, military status, genetic information, or have been sexually harassed by an employee of the employer or while working for the employer may file a complaint by completing this form and submitting it to the appointing authority.

Name of complainant: _____

Classification (if employee): _____

Address (if non-employee): _____

Basis of complaint: _____
(continue on back or
separate page if necessary)

Date(s) of incident(s): _____

If claiming discrimination
based on disability, what
accommodation do you
request? _____

**UNION COUNTY
PERSONNEL POLICY MANUAL**

EEO/ADA/DISCRIMINATORY HARASSMENT COMPLAINT FORM

**FORM Z
PAGE 2 OF 2**

If claiming discrimination
other than disability, what
resolution do you request?

Signature of complainant

Date

**UNION COUNTY
PERSONNEL POLICY MANUAL**

COMPLAINT FORM

**FORM AA
PAGE 1 OF 2**

Name of employee: _____

Classification: _____

Date of occurrence: _____

Date grievance was discussed with immediate supervisor: _____

STEP 1: IMMEDIATE SUPERVISOR

Date grievance was reduced to writing and presented: _____

Nature of grievance: what is the issue or allegation; what has been violated?

Employee signature

Date

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

Grievance must be filed with the employee's supervisor within five (5) working days from the date of the response received in the informal step to resolve the grievance.

(Hearing and response must be completed within five (5) working days of receipt of grievance)

Supervisor

Date received

Supervisor answer: _____

Supervisor signature

Date

**UNION COUNTY
PERSONNEL POLICY MANUAL**

COMPLAINT FORM

**FORM AA
PAGE 2 OF 2**

STEP 2: DEPARTMENT HEAD

Delivered by employee to the department head within five (5) working days of receipt of Step 1 answer.

Date submitted: _____ Received by: _____

Date of hearing: _____ (within five (5) working days of receipt)

Department head's answer (within five (5) working days of hearing):

Department head signature

Date

STEP 3: APPOINTING AUTHORITY

Delivered by employee to the appointing authority within five (5) working days of receipt of Step 2 answer.

Date submitted: _____ Received by: _____

Date of hearing: _____ (within five (5) working days of receipt)

Appointing authority's answer (within fifteen (15) working days following receipt of grievance):

Appointing authority signature

Date

**UNION COUNTY
PERSONNEL POLICY MANUAL**

RECORD OF VERBAL WARNING

FORM BB

Employee's name: _____

Classification: _____ Department: _____

TYPE OF VIOLATION: _____ Group: _____ Number: _____

- | | | | |
|---|--|---|--------------------------------------|
| <input type="checkbox"/> Incompetency | <input type="checkbox"/> Inefficiency | <input type="checkbox"/> Neglect of Duty | <input type="checkbox"/> Dishonesty |
| <input type="checkbox"/> Drunkenness | <input type="checkbox"/> Immoral Conduct | <input type="checkbox"/> Insubordination | <input type="checkbox"/> Misfeasance |
| <input type="checkbox"/> Malfeasance | <input type="checkbox"/> Nonfeasance | <input type="checkbox"/> Failure of Good Behavior | |
| <input type="checkbox"/> Discourteous Treatment of the Public | <input type="checkbox"/> Other: _____ | | |

Date violation occurred: _____

Location where violation occurred: _____

Description of violation: _____

(attach additional sheets if necessary)

Necessary corrective action: _____

(attach additional sheets if necessary)

This verbal warning is issued as a corrective measure in an effort to help you improve your conduct. This form will be removed from your personnel files after 24 months, if no intervening discipline during that period occurs. Any further violations could result in more severe disciplinary actions.

Signature of Person Issuing Warning

Title

I hereby acknowledge that a copy of the above *Record of Verbal Warning* has been given to me this day.

Signature of Employee

Date

Original: Personnel file
Copy: Employee

**UNION COUNTY
PERSONNEL POLICY MANUAL**

RECORD OF WRITTEN REPRIMAND

FORM CC

Employee's name: _____

Classification: _____ Department: _____

TYPE OF VIOLATION: _____ Group: _____ Number: _____

- | | | | |
|---|--|---|--------------------------------------|
| <input type="checkbox"/> Incompetency | <input type="checkbox"/> Inefficiency | <input type="checkbox"/> Neglect of Duty | <input type="checkbox"/> Dishonesty |
| <input type="checkbox"/> Drunkenness | <input type="checkbox"/> Immoral Conduct | <input type="checkbox"/> Insubordination | <input type="checkbox"/> Misfeasance |
| <input type="checkbox"/> Malfeasance | <input type="checkbox"/> Nonfeasance | <input type="checkbox"/> Failure of Good Behavior | |
| <input type="checkbox"/> Discourteous Treatment of the Public | <input type="checkbox"/> Other: _____ | | |

Date violation occurred: _____

Location where violation occurred: _____

Description of violation: _____

(attach additional sheets if necessary)

Necessary corrective action: _____

(attach additional sheets if necessary)

Date of prior verbal reprimand(s): _____

This written warning is issued as a corrective measure in an effort to help you improve your conduct. This reprimand will be removed from your personnel files after 24 months if no intervening discipline during that period occurs. Any further violations could result in more severe disciplinary actions.

Signature of Person Issuing Reprimand

Title

I hereby acknowledge that a copy of the above *Record of Written Reprimand* has been given to me this day.

Signature of Employee

Date

Original: Personnel file
Copy: Employee

**UNION COUNTY
PERSONNEL POLICY MANUAL**

NOTICE OF PREDISCIPLINARY CONFERENCE

FORM DD

Name: _____ Date: _____

Department: _____

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

Alleged Offense: _____

Type of Offense: _____ Group: _____ Number: _____

Summary of Charges _____

You have the right to: (1) appear at the conference to present an oral or written statement in your defense; (2) elect in writing to waive your opportunity to have a predisdisciplinary conference by signing the attached form and returning it to the undersigned. Failure to respond or respond truthfully may result in disciplinary action.

At the conference you may present any testimony or documents which explain whether or not the alleged misconduct occurred.

Waiver of Predisdisciplinary Conference

I (name) _____, on this (day) _____ of (month) _____, (year) _____, freely and voluntarily waive my right to a "predisdisciplinary conference" scheduled for (time) _____, (day) _____ of (month) _____, (year) _____, and (check one) ☐ admit or ☐ deny the charges and specifications contained in the Notice of Predisdisciplinary Conference attached hereto.

Signed: _____

Witnessed: _____

Time: _____ Date: _____

**UNION COUNTY
PERSONNEL POLICY MANUAL**

ORDER OF REMOVAL, SUSPENSION, OR REDUCTION (ADM 4055)

FORM EE

Available at

https://pbr.ohio.gov/wps/wcm/connect/gov/e4d802a5-61c2-486d-9182-56bd626e5231/124-34+Order+Form+-+Fillable.pdf?MOD=AJPERES&CONVERT_TO=url&CACHEID=ROOTWORKSPACE.Z18M1HGGIK0N0JO00QO9DDDDM3000-e4d802a5-61c2-486d-9182-56bd626e5231-n0lrgv-

**UNION COUNTY
PERSONNEL POLICY MANUAL**

EMPLOYEE INCIDENT AND INJURY REPORT

**FORM FF
PAGE 1 OF 3**

EMPLOYEE INCIDENT AND INJURY REPORT

INSTRUCTIONS: Employees involved in workplace accidents, injuries, and/or near-misses must complete this form and forward it to their supervisor. Workplace accidents and/or injuries must be reported to Human Resources within 24 hours. Attach additional pages and/or forms as necessary. If you have questions, please call Human Resources at (937) 645-3106.

Employee Name:	Position Title:
Department:	Work Phone:
Date of Incident: / /	Time of Incident: <input type="checkbox"/> A.M. <input type="checkbox"/> P.M.
Incident Reported To:	On (Date): / / at <input type="checkbox"/> A.M. <input type="checkbox"/> P.M.
Incident Location:	
Relevant Weather Conditions:	
On this day, how long were you performing this job or task?	
Was this activity part of your normal job duty? <input type="checkbox"/> Yes <input type="checkbox"/> No	

INCIDENT INFORMATION:

Type of Incident (check all that apply): ☐ Injury ☐ Property Damage ☐ Near Miss ☐ Other

Describe how the accident, injury or near miss occurred. Include details about what were you doing just before the event, where were you at the time of the event, and what you did after the event. Be specific. Attach any drawings, photos, supplemental attachments and/or police reports as necessary.

Cause of Incident:

List everyone who witnessed the incident(s):

**UNION COUNTY
PERSONNEL POLICY MANUAL**

EMPLOYEE INCIDENT AND INJURY REPORT

**FORM FF
PAGE 2 OF 3**

INJURY INFORMATION:

Did the incident result in injury? ☐ Yes ☐ No

If yes, please describe the injury. Be specific. Please list the body part(s) injured:

Check all types of injuries that apply:

☐ Abrasion/Scratch ☐ Bite/Sting ☐ Burn ☐ Contusion/Bruise ☐ Cut/Puncture ☐ Dislocation ☐ Fracture
☐ Sprain/Strain

Other:

Is this an aggravation of a previous injury/symptom? ☐ Yes ☐ No

If yes, when were you last treated?

Please describe the previous injury/symptoms:

TREATMENT INFORMATION:

Did you receive medical attention following this incident? (check all that apply)

☐ N/A ☐ Declined ☐ First Aid ☐ EMS/ER ☐ Urgent Care ☐ Dr. Office Visit ☐ Other:

Last day worked:

Date returned to work?

If not returned to date, estimated date of return:

Did anyone else receive medical attention? (check all that apply):

☐ N/A ☐ Declined ☐ First Aid ☐ EMS/ER ☐ Urgent Care ☐ Dr. Office Visit ☐ Other:

If yes, whom?

PROPERTY DAMAGE:

Was a Law Enforcement Report taken? ☐ Yes ☐ No Report #:

By Whom? ☐ Sheriff ☐ Marysville PD ☐ State Highway Patrol ☐ Other:

COUNTY PROPERTY:

Describe damage to equipment, vehicle(s) and/or other County property:

If driving, what type of vehicle were you driving? ☐ County-Owned ☐ Personal vehicle

Driver's License Number: Will your Driver's License remain active following this incident? ☐ Yes ☐ No

Vehicle Make:

Vehicle Model:

Vehicle Year:

NOTE: You must notify your supervisor immediately if there is a change in your driver's license status that impacts your ability to operate a county-owned vehicle. See the Use of County Vehicles policy for additional information and guidance.

List names of any passengers:

**UNION COUNTY
PERSONNEL POLICY MANUAL**

EMPLOYEE INCIDENT AND INJURY REPORT

**FORM FF
PAGE 3 OF 3**

Where were you traveling from?									
Where were you going?									
Are you familiar with the area? <input type="checkbox"/> Yes <input type="checkbox"/> No									
Describe the traffic conditions: <input type="checkbox"/> Light <input type="checkbox"/> Moderate <input type="checkbox"/> Heavy									
Were you wearing a seat belt at the time of the accident? <input type="checkbox"/> Yes <input type="checkbox"/> No									
Were you observing all traffic safety laws? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, please describe:									
Describe any unusual hazards or problems at the scene of the accident:									
<p style="text-align: center;">IF A THIRD PARTY WAS INVOLVED, PLEASE COMPLETE THIS SECTION:</p> <p>Describe damage to third party vehicle or other property:</p> <table style="width: 100%;"><tr><td style="width: 33%;">Driver's Name (if applicable):</td><td style="width: 33%;">Driver's License Number:</td><td style="width: 33%;">Phone Number:</td></tr><tr><td>Vehicle Make:</td><td>Vehicle Model:</td><td>Insurance Carrier:</td></tr><tr><td>Property Owner's Name (if different than driver):</td><td></td><td>Phone Number:</td></tr></table>	Driver's Name (if applicable):	Driver's License Number:	Phone Number:	Vehicle Make:	Vehicle Model:	Insurance Carrier:	Property Owner's Name (if different than driver):		Phone Number:
Driver's Name (if applicable):	Driver's License Number:	Phone Number:							
Vehicle Make:	Vehicle Model:	Insurance Carrier:							
Property Owner's Name (if different than driver):		Phone Number:							

EMPLOYEE CERTIFICATION: By signing this form, I am certifying that the information provided about this incident is correct and accurate to the best of my knowledge. I understand that failure to disclose, provide, or represent relevant and truthful information may result in disciplinary action up to and including discharge. I understand that I must also participate fully and honestly in any related investigations.

EMPLOYEE SIGNATURE

SUPERVISOR SIGNATURE

DEPARTMENT HEAD SIGNATURE

**UNION COUNTY
PERSONNEL POLICY MANUAL**

SUPERVISOR'S INCIDENT INVESTIGATION REPORT

**FORM GG
PAGE 1 OF 1**

INSTRUCTIONS: This form is completed during the investigation of employee incidents involving workplace accidents, injuries and/or near misses. This form should be submitted to Human Resources – along with the Employee Incident Report and any Witness Statements – as soon as possible following an incident. Attach additional pages and/or forms as necessary. If you have questions, please call Human Resources at (937) 645-3106.

Employee Involved:		Position Title:	
Date of Incident: / /		Time of Incident: <input type="checkbox"/> A.M. <input type="checkbox"/> P.M.	
Incident Location:			
Supervisor:	Date and Time Incident Reported: / / at <input type="checkbox"/> A.M. <input type="checkbox"/> P.M.		
Check the following if they resulted from the accident (select all that apply):			
<input type="checkbox"/> Injury If someone was injured, please list who:			
Was medical attention needed? <input type="checkbox"/> No <input type="checkbox"/> Declined <input type="checkbox"/> First Aid <input type="checkbox"/> EMS /ER <input type="checkbox"/> Urgent Care <input type="checkbox"/> Other:			
<input type="checkbox"/> Damage to County Property	Estimated Damage to County Property (if known): \$		
<input type="checkbox"/> Damage to Third Party Property	Estimated Damage to Third Party Property (if known): \$		
Describe any injury(ies) and/or property damage that resulted from the accident:			
Will the employee have work restrictions or remain under doctor's care? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
Will the employee miss at least one full day of work? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
Last Day Worked: / /	Did the employee request light duty? <input type="checkbox"/> Yes <input type="checkbox"/> No	Return to Work Date: / /	
Was the task work-related and within the employee's scope of employment?			<input type="checkbox"/> Yes <input type="checkbox"/> No
Was the employee adequately trained in the task?			<input type="checkbox"/> Yes <input type="checkbox"/> No
Was the employee properly using all safety equipment and personal protective equipment (PPE)?			<input type="checkbox"/> Yes <input type="checkbox"/> No
Was the employee observing all safety rules and policies?			<input type="checkbox"/> Yes <input type="checkbox"/> No
Did the employee follow proper protocols after the workplace accident or injury?			<input type="checkbox"/> Yes <input type="checkbox"/> No
How did the accident occur?			
What was the cause of the accident? (see reverse)			
What are your recommendations to prevent recurrence? (see reverse)			
What corrective measures should be taken? (see reverse)			
Person Conducting Investigation (PRINT):			
Signature:		Date:	

**UNION COUNTY
PERSONNEL POLICY MANUAL**

WORKPLACE VIOLENCE INCIDENT REPORT

FORM HH

Date of incident: _____

Facts of incident: _____

Statement(s) of Witness(es):

1. _____

Signature(s) of Witness(es): _____

2. _____

Signature(s) of Witness(es): _____

3. _____

Signature(s) of Witness(es): _____

4. _____

Signature(s) of Witness(es): _____

Proposed action to prevent situation from occurring again: _____

Signature of Supervisor or Department Head

Date

**UNION COUNTY
PERSONNEL POLICY MANUAL**

WITNESS STATEMENT

FORM II

INSTRUCTIONS: Please complete this form if you have witnessed or were involved in a Union County incident involving a workplace accident, injury, or near-miss. This form should be completed within 24 hours of an incident and returned to the Union County Human Resources Department at 233. W. Sixth St., Marysville, OH. Attach additional pages or forms as necessary. If you have questions, please call Human Resources at (937) 645-3106.

CONTACT INFORMATION	
Your Name:	Phone Number: () -
Address:	
Age (if under 18):	Legal Guardian, if minor:
Are you a Union County employee? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, please provide your Position Title and Department/Division:	
DESCRIPTION OF INCIDENT	
What resulted from the incident you observed? (check all that apply):	
<input type="checkbox"/> Injury <input type="checkbox"/> Property Damage <input type="checkbox"/> Near Miss <input type="checkbox"/> Other (please describe):	
Location of Incident:	
Describe what you observed and how the accident, injury, or other incident occurred (use reverse side of paper if needed):	
Describe the weather conditions (if relevant):	
Who was involved? Please list any other individuals who were present.	
Date of Incident: / /	Time of Incident: <input type="checkbox"/> A.M. <input type="checkbox"/> P.M.
County Official Incident was reported to:	Date Reported: / /
OTHER INFORMATION	
Is there any other information you would like to provide relating to this incident?	
SIGNATURE:	DATE:

Please return this form to Union County Human Resources, located at 233 W. Sixth St., Marysville, Ohio.

**Phone: (937) 645-3106
Fax: (937) 645-3072
Email: HR@unioncountyoio.gov**

**UNION COUNTY
PERSONNEL POLICY MANUAL**

**WORKPLACE SAFETY AND ILLEGAL ACTIVITY
ACKNOWLEDGMENT**

FORM JJ

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 superior if he or she 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 superior, and to do so before reporting the issue to other authorities, pursuant to the requirements of Ohio law.

Employee signature

Date

**UNION COUNTY
PERSONNEL POLICY MANUAL**

WORKPLACE SAFETY REPORT

FORM KK

Department/Office: _____

Location and nature of rules or workplace safety violation: _____

My suggested remedy(ies): _____

Employee signature

Date

SUPERVISOR'S REPLY TO EMPLOYEE

Supervisor signature

Date

**UNION COUNTY
PERSONNEL POLICY AND PROCEDURES MANUAL**

**REQUEST FOR THE INSPECTION/RELEASE
OF PUBLIC RECORDS**

FORM LL

_____ Representing _____
(Name) (Organization)

_____ Requesting to _____ Inspect
(Name)

and/or _____ Obtain copies of the following public payroll records:

In exchange for the inspection and/or release of the payroll information identified above, the undersigned individual/organization agrees to indemnify and hold harmless Union County and its officials for any and all liability directly or indirectly arising from the inspection and/or release of said public records.

OFFICE USE ONLY

Number of copies @ actual cost per copy = _____

Payment received by _____ Date _____

**UNION COUNTY
PERSONNEL POLICY MANUAL**

PUBLIC RECORDS RESPONSE

FORM MM

Thank you for recent public records request. Union County will respond in accordance to the applicable provisions the Ohio Public Records Act and both State and Federal law.

Request Number: _____ Response Date: _____

You requested the following records: _____

Public Records Released? ☐ YES ☐ NO

If **REDACTED**, please check the reason(s) below:

- ☐ Social Security Number – ORC 149.43(A)(1)(dd)
- ☐ Driver's License Number – ORC 149.43(A)(1)(dd)
- ☐ Medical Records – ORC 149.43(A)(1)(a)
- ☐ Confidential Law Enforcement Investigatory Records – ORC 149.43(A)(1)(h)
- ☐ Personal Address of a Designated Public Service Worker – 149.43(A)(8)(a)
- ☐ Non-records (such as home address, home and personal cell phone numbers, personal e-mail address, etc.) that are maintained only for administrative convenience and not to document the formal duties and activities of the office, pursuant to *State ex rel. McCleary v. Roberts*, 88 Ohio St.3d 365, 365 (2000); *State ex rel. Fant v. Enright*, 66 Ohio St.3d 186, 188 (1993).
- ☐ _____ has been redacted according to the following law: _____.

If **NOT** released, please check the reason below:

- ☐ Record is not maintained by this office
- ☐ Is overly ambiguous despite efforts to clarify – ORC 149.43(B)(2)
- ☐ Record has met retention period and has been disposed of properly – ORC 149.38
- ☐ Record is exempt from disclosure per ORC: _____
- ☐ Record does not exist/or no obligation to create – ORC 149.40

**UNION COUNTY
PERSONNEL POLICY MANUAL**

OHIO PUBLIC RECORDS LAW POSTER

FORM NN



OHIO PUBLIC RECORDS LAWS

Ohio's Public Records Laws ensure public access to public records and are a means to provide trust between the public and your office. Essentially any record created, received or maintained in Union County, with a few specific exceptions, are a public record.

A record can be on paper or microfilm, electronic on your computer or in a database, accessed through your website, or on a hand-held device such as a cell phone or Blackberry. Basically anything created, received, stored or maintained on or in county-owned equipment or supplies can be considered a public record. Records include files, letters, reports and memos as well as e-mails, text messages, phone logs, and phone messages. Keep in mind that if you conduct County business on your personal phone or computer, those records could also be considered to be public.

Public records should be maintained in a manner that provides for prompt inspection and copying within a reasonable amount of time during the office's regular business hours. Your supervisor or manager will advise you as to what records might be considered confidential. Additionally, no public records should ever be destroyed without following approved procedures, you should contact your supervisor or manager before you dispose of any records.

There are a few specific exceptions in the public record laws, and employees are not expected to know every exception to the definition of a public record. If you are presented with a public records request and are unsure how to proceed, tell the person making the request that you will forward it to your supervisor. Others who have been trained in the Public Records Law will be responsible for releasing information.

If you would like more information on your duties and responsibilities in regards to the public record laws, every office has a policy regarding public records (whether it was created by the office themselves or in the Union County Personnel Policy Manual). Please ask your supervisor or manager for a copy of the policy that their office follows. Thank you for your attention to this important matter of public interest.

**UNION COUNTY
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OHIO ETHICS LAW AND RELATED STATUTES

FORM OO

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 Director of Human Resources Officer can provide you with a hard copy of the document to review.

**UNION COUNTY
PERSONNEL POLICY MANUAL**

OHIO ETHICS LAWS ACKNOWLEDGMENT

FORM PP

I hereby acknowledge receipt of the Ohio Ethics Law and Related Statutes. I further acknowledge that I understand and agree to abide by these ethics while in the employ of Union County.

Employee signature

Date

FORM QQ
PAGE 1 OF 3

**UNION COUNTY
PERSONNEL POLICY MANUAL**

REQUEST FOR PRECINCT ELECTION OFFICIALS LEAVE

**FORM QQ
PAGE 2 OF 3**

Procedure:

Employees requesting Precinct Election Official leave and Supervisors/Appointing Authorities who receive requests for leave must follow the procedures established:

1. A request for leave to serve as a Precinct Election Official on Election Day shall be submitted to the employee's immediate supervisor at least 14 calendar days prior to the date of the election or as soon as practical. To request the time off, the employee must complete the standard "Request for Precinct Election Officials Leave" form as prescribed by the Board of Elections.
2. Upon receiving a properly completed "Request for Precinct Election Officials Leave" form, the immediate supervisor shall note the date and time the request was received on the form. If the form is not completed properly, the supervisor shall notify the employee prior to marking the form for processing.
3. Request for Precinct Election Official leave shall be subject to the operational needs of the employee's Office/Agency/Department and will be given the lowest priority as compared to other types of leave requests for the same date within that Office/Agency/Department. Specialized roles as defined by the BOE will be given priority status.
4. For the first election following program adoption/implementation, employee(s) with the most years of service as an Election Official shall be permitted to receive Precinct Election Official leave. For subsequent elections, the employee(s) who have served as Precinct Election Officials in the immediately preceding election will move to the bottom of the eligibility list for Precinct Election Official leave in order of seniority, except when the position is specialized, as defined by the Board of Elections.
5. The immediate supervisor may revoke the approval for Precinct Election Official leave based on operational needs of the Office/Agency/Department. It is the employee's responsibility to notify the Board of Elections if the employee is no longer able to serve as a Precinct Election Official on Election Day.
6. Following the election, the Auditor's Office and the Board of Elections will verify that the employee served, as planned, on Election Day.
7. Any employee who fails to follow the procedures set forth may be subject to disciplinary action, will not receive Election Officials Leave, and may not be considered for this type of leave in the future.

If you have any questions about this program or serving as a Precinct Election Official, please contact the Union County Board of Elections at 937-642-2836 or email us at boardofelections@unioncountyohio.gov.

**UNION COUNTY
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REQUEST FOR PRECINCT ELECTION OFFICIALS LEAVE

**FORM QQ
PAGE 3 OF 3**

Precinct Election Officials FAQs

What are the qualifications for serving as a Precinct Election Official (PEO)?

- **PEOs must meet the following minimum requirements to be considered for the position:** At least 17 years of age and registered to vote in Union County; have not been convicted of a felony; have transportation to and from the polling location; must not be running as a candidate in the election for which they are working.
- **Physical Requirements:** Have the ability to sit or stand for the entire 15-hour day.
- **Personal Traits:** Professionalism and courtesy to all voters and the ability to work in a team-oriented environment.

How long is an election day, typically?

- **15 Hours.** You must arrive at your assigned polling location at 5:30am and can typically leave around 8:30pm (approximately).

Is this a paid position?

- **Yes.** Base pay for Precinct Election Officials is \$133 for the day (paid for by the BOE), but certain positions can earn more based on the training that is required. You will also receive your regular wages (from your Office/Agency) for the day if you would normally be scheduled to work on Election Day.

Is training mandatory?

- **Yes.** The BOE pays PEOs \$25 for most trainings. This may be different for specialized positions. Training will last between 3-4 hours and you will have several dates to choose from. Training is mandatory for every PEO in the state of Ohio.

Where will I work?

- Efforts are made to assign PEOs in their home precinct, however, this does not always happen. We try to assign you as close to home as possible.

Do I have to be affiliated with a political party?

- No. Non-partisan voters may serve as PEOs, however, per the Ohio Revised Code, we must staff the election with two (2) Democrats and two (2) Republicans. For non-partisan voters, this means that you will serve as a representative of one of the two major political parties.

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REQUEST FOR LEAVE WITHOUT PAY (LWOP)

**FORM RR
PAGE 1 OF 1**

Employee name: _____ Date: _____

Reason for leave: _____

(Attach any supporting documentation, as necessary)

Beginning date/time of leave: _____ Ending date/time of leave: _____

TOTAL # OF HOURS REQUESTED: _____

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

Employee Signature _____ Date _____

ADMINISTRATIVE ACTION:

Supervisor: ☐ Approved ☐ Not approved (Signature) _____

Department head: ☐ Approved ☐ Not approved (Signature) _____

Appointing authority: ☐ Approved ☐ Not approved (Signature) _____