APPLICATION
FOR EMPLOYMENT

Please type or print in ink only

Bruning-Davenport Unified School District is an Equal Opportunity Employer. We consider applicants for all jobs without regard to race, color, sex, pregnancy, national origin, marital status, disability, religion, age (40 years of age or older), or any other legally protected status. Applicants who need a reasonable accommodation to complete this application may contact the HR Director for assistance. The Title IX Coordinator is the Activities Director who may be contacted in person, by mail, by telephone, or by electronic mail at 402-353-4685

Position Applied For _____ Date of Application _____

Last Name _____ First Name _____ Middle Initial _____

Present Address (Number and Street) _____ City _____ State _____ Zip _____

Telephone Number(s): Home ( ) _____ Cell ( ) _____

Email Address: _____

CERTIFICATION OF MINIMUM EMPLOYMENT QUALIFICATIONS

- ☐ I am a high school graduate or hold a GED
- ☐ I can understand and follow verbal directions
- ☐ I can understand and follow written directions
- ☐ I have not been convicted of a crime involving physical or sexual abuse
- ☐ I can, after being hired, verify my legal right to work in the United States

If you have checked all the boxes above, please continue to the second page
If any box above is unchecked, please submit the application now.

Have you ever been employed with us before? _____ Yes _____ No

If yes, provide date(s) _____ to _____
and Department _____

Are you under 18 years of age? _____ Yes _____ No

If you are under the age of 18, you may need to supply the School District a work permit or limit your hours to those permitted by law.

May we contact your current employer? _____ Yes _____ No

Have you ever been terminated from employment? _____ Yes _____ No

Have you ever been notified of possible cancelation, termination or non-renewal of employment? _____ Yes _____ No
If yes, please explain the circumstances:

Have you ever resigned to avoid being notified of possible cancellation, termination or non-renewal of your employment?
_____ Yes _____ No
If yes, please explain the circumstances:

Have you ever had a complaint filed against you with the Professional Practices Committee of the Nebraska Department of Education? _____ Yes _____ No
If yes, please explain the circumstances and the outcome:

Specify days and hours for which you are available: _____

Date available to start work? _____

If the job you are applying for requires a valid driver's license, please complete the information below:

Number _____ State _____ Regular _____ CDL _____

Do you have any relatives presently employed by the School District? _____ Yes _____ No

If yes, give names, divisions and relationship: _____

Are you willing to work overtime if required? _____ Yes _____ No

Are you willing to work different shifts, if required? _____ Yes _____ No

IT IS THE POLICY OF THE SCHOOL DISTRICT TO CONDUCT A CRIMINAL HISTORY RECORD INFORMATION CHECK FOR ALL APPLICANTS AFTER THE SCHOOL DISTRICT MAKES A DETERMINATION THAT THE APPLICANT IS QUALIFIED FOR EMPLOYMENT AND PRIOR TO THE APPLICANT'S FIRST DATE OF EMPLOYMENT WITH THE SCHOOL DISTRICT. If selected as a final candidate, you will be required to disclose your criminal history or record. Convictions are not an automatic bar from employment, but will be considered as part of the totality of your suitability. You will not be required to disclose any offense for which the record has been sealed. The School District will not ask you to disclose the contents or details of any sealed records or that any sealed records exist.

EMPLOYMENT EXPERIENCE

Start with your current or last job and complete the information below.
(Attach additional sheets if necessary)

Employer Name Address (Street, City, Zip) Employed From To

Job Title Supervisor Supervisor Phone No.

Starting Wage Ending Wage Reason for Leaving

Summarize nature of work performed

Employer Name Address (Street, City, Zip) Employed From To

Job Title Supervisor Supervisor Phone No.

Starting Wage Ending Wage Reason for Leaving

Summarize nature of work performed

Employer Name Address (Street, City, Zip) Employed From To

Job Title Supervisor Supervisor Phone No.

Starting Wage Ending Wage Reason for Leaving

Summarize nature of work performed

_____

_____

Employer Name Address (Street, City, Zip) Employed From To

_____

Job Title Supervisor Supervisor Phone No.

_____

Starting Wage Ending Wage Reason for Leaving

_____

Summarize nature of work performed

_____

Have you served in the United States Armed Forces? _____ Yes _____ No

If yes, please give dates of military service: From _____ To _____

Branch? _____

Summarize nature of work performed: _____

_____

Are you claiming veterans' preference? _____ Yes _____ No

If yes, a copy of your DD Form 214 must be attached to this application and additional documentation must be provided upon request to determine eligibility. This position is subject to a veterans preference. The School District shall give a preference to eligible veterans, veterans' spouses, and/or servicemembers' spouses as required by law. If employment is conditioned on passing an examination, eligible individuals who obtain passing scores on all parts or phases of the examination shall have five percent added to their passing score if a claim for such preference is made on the application. An additional five percent shall be added to the passing score of any disabled veteran.

EDUCATIONAL BACKGROUND
(Attach additional sheets if necessary)

_____ 9 _____ 10 _____ 11 _____ 12 _____

High School Name and Location (mark highest grade completed)

_____

Community College School / Location Course of Study

Graduated? _____ Yes _____ No Degree Obtained? _____ Yes _____ No

_____

Trade School School / Location Course of Study

Graduated? _____ Yes _____ No Degree Obtained? _____ Yes _____ No

_____

College / University | School / Location | Course of Study

Graduated? _____ Yes _____ No Degree Obtained? _____ Yes _____ No

Seminars / Other | Please describe

SPECIAL SKILLS

Computer Skills (please explain your level of proficiency below):

Use the space below to summarize other relevant experience, skills, background, training and qualifications that you feel make you especially suited for work with the School District.

REFERENCES
(List three individuals familiar with your work ability. Do not include relatives.)

Name	Address (Street, City, Zip)	Phone No.	Relationship to Person
Name	Address (Street, City, Zip)	Phone No.	Relationship to Person
Name	Address (Street, City, Zip)	Phone No.	Relationship to Person

APPLICANT'S STATEMENT

I certify that answers given in this application are true and complete to the best of my knowledge. I understand that false, misleading or omitted information given in my application or interview(s) may result in discharge.

Signature Date

CONSENT TO PROVIDE EMPLOYMENT HISTORY
TO PROSPECTIVE EMPLOYERS

I, _____ (applicant), consent to any and all of my former employers to provide information regarding my employment to any prospective employer(s) who contact them.

I consent to the disclosure of the following information about me by any and all of my former employers:

1. **Date and duration of employment;**
2. **Pay rate and wage history on the date of receipt of this consent;**
3. **Job description and duties;**
4. **The most recent written performance evaluation prepared prior to the date of the request for information and provided to me during the course of my employment;**
5. **Attendance information;**
6. **Results of drug or alcohol tests administered within one year prior to the request for information;**
7. **Threats of violence, harassing acts, or threatening behavior related to the workplace or directed at another employee;**
8. **Whether I was voluntarily or involuntarily separated from employment and the reasons for the separation; and**
9. **Whether I am eligible for rehire.**

The consent is valid for six months from the date of my signature below.

_____	_____	_____
Printed Name	**Signature**	**Date**

Criminal History Disclosure and
Acknowledgment and Authorization
For Criminal Background Check

Criminal History Disclosure

Have you been convicted of a felony or misdemeanor in the last seven years? _____ Yes _____ No

(Convictions do not necessarily bar you from employment, but will be considered as part of the totality of your suitability. You are not obligated to disclose any offense for which the record has been sealed. The School District is not asking you to disclose the contents or details of any sealed records or that any sealed records exist.)

If yes, please explain: _____

Acknowledgment and Authorization for Criminal Background Check

As a condition of my candidacy for employment with the School District, I understand that the School District will conduct a criminal background check for employment purposes.

By signing this Acknowledgment and Authorization, I authorize the School District, or any other company authorized by the School District, to access such information as may be necessary to complete a criminal background check.

I release from liability all persons and entities supplying such information. I indemnify the School District, or any other company authorized by the School District, against any liability which may result from making such requests. I agree that a fax or photocopy of the Acknowledgment and Authorization with my signature will be accepted with the same authority as the original.

I believe to the best of my knowledge that all information provided below is accurate, true and correct, and that I fully understand the terms of this Acknowledgment and Authorization.

Printed Name: _____

Other Names Used: _____

Current Address: _____

City: _____ State: _____ Zip Code: _____ Country: _____

Social Security Number: _____ Date of Birth: _____

Sex: _____ Race: _____ Driver's License Number and State: _____

Signature: _____ Date: _____

Certification for Serious Injury or Illness of a Veteran for Military Caregiver Leave (Family and Medical Leave Act)

U.S. Department of Labor

Wage and Hour Division

DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR; RETURN TO THE EMPLOYEE

OMB Control Number: 1235-0003
Expires: 8/31/2021

Notice to the EMPLOYER

The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking military caregiver leave under the FMLA leave due to a serious injury or illness of a covered veteran to submit a certification providing sufficient facts to support the request for leave. Your response is voluntary. While you are not required to use this form, you may not ask the employee to provide more information than allowed under the FMLA regulations, 29 CFR 825.310. Employers must generally maintain records and documents relating to medical certifications, recertifications, or medical histories of employees or employees' family members, created for FMLA purposes as confidential medical records in separate files/records from the usual personnel files and in accordance with 29 CFR 1630.14(c)(1), if the Americans with Disabilities Act applies, and in accordance with 29 CFR 1635.9, if the Genetic Information Nondiscrimination Act applies.

SECTION I: For completion by the EMPLOYEE and/or the VETERAN for whom the employee is requesting leave

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

(This section must be completed before Section II can be completed by a health care provider.)

Part A: EMPLOYEE INFORMATION

Name and address of employer (this is the employer of the employee requesting leave to care for a veteran):

_____

Name of employee requesting leave to care for a veteran:

_____
First Middle Last

Name of veteran (for whom employee is requesting leave):

_____
First Middle Last

Relationship of employee to veteran:

Spouse☐ Parent☐ Son☐ Daughter☐ Next of Kin ☐ (please specify relationship):

Part B: VETERAN INFORMATION

(1) Date of the veteran's discharge:

_____

(2) Was the veteran **dishonorably** discharged or released from the Armed Forces (including the National Guard or Reserves)? Yes☐ No☐

(3) Please provide the veteran's military branch, rank and unit at the time of discharge:

_____

(4) Is the veteran receiving medical treatment, recuperation, or therapy for an injury or illness?
Yes☐ No☐

Part C: CARE TO BE PROVIDED TO THE VETERAN

Describe the care to be provided to the veteran and an estimate of the leave needed to provide the care:

_____

_____

SECTION II: For completion by: (1) a United States Department of Defense ("DOD") health care provider; (2) a United States Department of Veterans Affairs ("VA") health care provider; (3) a DOD TRICARE network authorized private health care provider; (4) a DOD non-network TRICARE authorized private health care provider; or (5) a health care provider as defined in 29 CFR 825.125.

INSTRUCTIONS to the HEALTH CARE PROVIDER: The employee named in Section I has requested leave under the military caregiver leave provision of the FMLA to care for a family member who is a veteran. For purposes of FMLA military caregiver leave, a serious injury or illness means an injury or illness incurred by the servicemember in the line of duty on active duty in the Armed Forces (or that existed before the beginning of the servicemember's active duty and was aggravated by service in the line of duty on active duty in the Armed Forces) and manifested itself before or after the servicemember became a veteran, and is:

(i) a continuation of a serious injury or illness that was incurred or aggravated when the covered veteran was a member of the Armed Forces and rendered the servicemember unable to perform the duties of the servicemember's office, grade, rank, or rating; or
(ii) a physical or mental condition for which the covered veteran has received a U.S. Department of Veterans Affairs Service Related Disability Rating (VASRD) of 50 percent or greater, and such VASRD rating is based, in whole or in part, on the condition precipitating the need for military caregiver leave; or
(iii) a physical or mental condition that substantially impairs the covered veteran's ability to secure or follow a substantially gainful occupation by reason of a disability or disabilities related to military service, or would do so absent treatment; or
(iv) an injury, including a psychological injury, on the basis of which the covered veteran has been enrolled in the Department of Veterans' Affairs Program of Comprehensive Assistance for Family Caregivers.

A complete and sufficient certification to support a request for FMLA military caregiver leave due to a covered veteran's serious injury or illness includes written documentation confirming that the veteran's injury or illness was incurred in the line of duty on active duty or existed before the beginning of the veteran's active duty and was aggravated by service in the line of duty on active duty, and that the veteran is undergoing treatment, recuperation, or therapy for such injury or illness by a health care provider listed above. Answer fully and completely all applicable parts. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can; terms such as "lifetime," "unknown," or "indeterminate" may not be sufficient to determine FMLA military caregiver leave coverage. Limit your responses to the veteran's condition for which the employee is seeking leave. Do not provide information about genetic tests, as defined in 29 CFR 1635.3(f), or genetic services, as defined in 29 CFR 1635.3(e).

(Please ensure that Section I has been completed before completing this section. Please be sure to sign the form on the last page and return this form to the employee requesting leave (See Section I, Part A above). **DO NOT SEND THE COMPLETED FORM TO THE WAGE AND HOUR DIVISION.**)

Part A: HEALTH CARE PROVIDER INFORMATION

Health care provider's name and business address:

_____

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

Type of Practice/Medical Specialty: _____

Please indicate if you are:

☐ a DOD health care provider

☐ a VA health care provider

☐ a DOD TRICARE network authorized private health care provider

☐ a DOD non-network TRICARE authorized private health care provider

☐ other health care provider

PART B: MEDICAL STATUS

Note: If you are unable to make certain of the military-related determinations contained in Part B, you are permitted to rely upon determinations from an authorized DOD representative (such as, DOD Recovery Care Coordinator) or an authorized VA representative.

(1) The Veteran's medical condition is:

☐ A continuation of a serious injury or illness that was incurred or aggravated when the covered veteran was a member of the Armed Forces and rendered the servicemember unable to perform the duties of the servicemember's office, grade, rank, or rating.

☐ A physical or mental condition for which the covered veteran has received a U.S. Department of Veterans Affairs Service Related Disability Rating (VASRD) of 50% or higher, and such VASRD rating is based, in whole or in part, on the condition precipitating the need for military caregiver leave.

☐ A physical or mental condition that substantially impairs the covered veteran's ability to secure or follow a substantially gainful occupation by reason of a disability or disabilities related to military service, or would do so absent treatment.

☐ An injury, including a psychological injury, on the basis of which the covered veteran is enrolled in the Department of Veterans' Affairs Program of Comprehensive Assistance for Family Caregivers.

☐ None of the above.

(2) Is the veteran being treated for a condition which was incurred or aggravated by service in the line of duty on active duty in the Armed Forces? Yes☐ No☐

(3) Approximate date condition commenced: _____

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

(5) Is the veteran undergoing medical treatment, recuperation, or therapy for this condition? Yes☐ No☐

If yes, please describe medical treatment, recuperation or therapy:

_____

PART C: VETERAN'S NEED FOR CARE BY FAMILY MEMBER

"Need for care" encompasses both physical and psychological care. It includes situations where, for example, due to his or her serious injury or illness, the veteran is unable to care for his or her own basic medical, hygienic, or nutritional needs or safety, or is unable to transport him or herself to the doctor. It also includes providing psychological comfort and reassurance which would be beneficial to the veteran who is receiving inpatient or home care.

(1) Will the veteran need care for a single continuous period of time, including any time for treatment and recovery? Yes☐ No☐

If yes, estimate the beginning and ending dates for this period of time: _____

(2) Will the veteran require periodic follow-up treatment appointments? Yes☐ No☐

If yes, estimate the treatment schedule: _____

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

(4) Is there a medical necessity for the veteran to have periodic care for other than scheduled follow-up treatment appointments (e.g., episodic flare-ups of medical condition)? Yes☐ No☐

If yes, please estimate the frequency and duration of the periodic care:

_____

_____

Signature of Health Care Provider: _____ Date: _____

PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT

If submitted, it is mandatory for employers to retain a copy of this disclosure in their records for three years, in accordance with 29 U.S.C. 2616; 29 CFR 825.500. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. The Department of Labor estimates that it will take an average of 20 minutes for respondents to complete this collection of information, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, U.S. Department of Labor, Room S-3502, 200 Constitution Ave., NW, Washington, DC 20210. **DO NOT SEND THE COMPLETED FORM TO THE WAGE AND HOUR DIVISION; RETURN IT TO THE EMPLOYEE REQUESTING LEAVE (As shown in Section I, Part "A" above).**

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

U.S. Department of Labor

Wage and Hour Division

DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR; RETURN TO THE PATIENT

OMB Control Number: 1235-0003
Expires: 8/31/2021

Notice to the EMPLOYER

INSTRUCTIONS to the EMPLOYER: The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA leave due to a serious injury or illness of a current servicemember to submit a certification providing sufficient facts to support the request for leave. Your response is voluntary. While you are not required to use this form, you may not ask the employee to provide more information than allowed under the FMLA regulations, 29 CFR 825.310. Employers must generally maintain records and documents relating to medical certifications, recertifications, or medical histories of employees or employees' family members created for FMLA purposes as confidential medical records in separate files/records from the usual personnel files and in accordance with 29 CFR 1630.14(c)(1), if the Americans with Disabilities Act applies, and in accordance with 29 CFR 1635.9, if the Genetic Information Nondiscrimination Act applies.

SECTION I: For Completion by the EMPLOYEE and/or the CURRENT SERVICEMEMBER for whom the Employee Is Requesting Leave

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

SECTION II: For Completion by a UNITED STATES DEPARTMENT OF DEFENSE ("DOD") HEALTH CARE PROVIDER or a HEALTH CARE PROVIDER who is either: (1) a United States Department of Veterans Affairs ("VA") health care provider; (2) a DOD TRICARE network authorized private health care provider; (3) a DOD non-network TRICARE authorized private health care provider; or (4) a health care provider as defined in 29 CFR 825.125

INSTRUCTIONS to the HEALTH CARE PROVIDER: The employee listed on Page 2 has requested leave under the FMLA to care for a family member who is a current member of the Regular Armed Forces, the National Guard, or the Reserves who is undergoing medical treatment, recuperation, or therapy, is otherwise in outpatient status, or is otherwise on the temporary disability retired list for a serious injury or illness. For purposes of FMLA leave, a serious injury or illness is one that was incurred in the line of duty on active duty in the Armed Forces or that existed before the beginning of the member's active duty and was aggravated by service in the line of duty on active duty in the Armed Forces that may render the servicemember medically unfit to perform the duties of his or her office, grade, rank, or rating.

A complete and sufficient certification to support a request for FMLA leave due to a current servicemember's serious injury or illness includes written documentation confirming that the servicemember's injury or illness was incurred in the line of duty on active duty or if not, that the current servicemember's injury or illness existed before the beginning of the servicemember's active duty and was aggravated by service in the line of duty on active duty in the Armed Forces, and that the current servicemember is undergoing treatment for such injury or illness by a health care provider listed above. Answer, fully and completely, all applicable parts. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can; terms such as "lifetime," "unknown," or "indeterminate" may not be sufficient to determine FMLA coverage. Limit your responses to the servicemember's condition for which the employee is seeking leave. Do not provide information about genetic tests, as defined in 29 CFR 1635.3(f), or genetic services, as defined in 29 CFR 1635.3(e).

SECTION I: For Completion by the EMPLOYEE and/or the CURRENT SERVICEMEMBER for whom the Employee Is Requesting Leave:

(This section must be completed first before any of the below sections can be completed by a health care provider.)

Part A: EMPLOYEE INFORMATION

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

_____

Name of Employee Requesting Leave to Care for the Current Servicemember:

_____

First Middle Last

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

_____

First Middle Last

Relationship of Employee to the Current Servicemember:

Spouse☐ Parent ☐ Son ☐ Daughter ☐ Next of Kin ☐

Part B: SERVICEMEMBER INFORMATION

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

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

_____

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

If yes, please provide the name of the medical treatment facility or unit:

_____

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

Part C: CARE TO BE PROVIDED TO THE SERVICEMEMBER

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

_____

_____

SECTION II: For Completion by a United States Department of Defense ("DOD") Health Care Provider or a Health Care Provider who is either: (1) a United States Department of Veterans Affairs ("VA") health care provider; (2) a DOD TRICARE network authorized private health care provider; (3) a DOD non-network TRICARE authorized private health care provider; or (4) a health care provider as defined in 29 CFR 825.125. If you are unable to make certain of the military-related determinations contained below in Part B, you are permitted to rely upon determinations from an authorized DOD representative (such as a DOD recovery care coordinator).

(Please ensure that Section I above has been completed before completing this section. Please be sure to sign the form on the last page.)

Part A: HEALTH CARE PROVIDER INFORMATION

Health Care Provider's Name and Business Address:

_____

Type of Practice/Medical Specialty: _____

Please state whether you are either: (1) a DOD health care provider; (2) a VA health care provider; (3) a DOD TRICARE network authorized private health care provider; (4) a DOD non-network TRICARE authorized private health care provider, or (5) a health care provider as defined in 29 CFR 825.125:

_____

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

PART B: MEDICAL STATUS

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

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

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

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

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

(2) Is the current Servicemember being treated for a condition which was incurred or aggravated by service in the line of duty on active duty in the Armed Forces? Yes☐ No☐

(3) Approximate date condition commenced: _____

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

(5) Is the servicemember undergoing medical treatment, recuperation, or therapy for this condition? Yes☐ No☐

If yes, please describe medical treatment, recuperation or therapy:

_____

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

(1) Will the servicemember need care for a single continuous period of time, including any time for treatment and recovery? Yes☐ No☐

If yes, estimate the beginning and ending dates for this period of time: _____

(2) Will the servicemember require periodic follow-up treatment appointments? Yes☐ No☐

If yes, estimate the treatment schedule: _____

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

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

If yes, please estimate the frequency and duration of the periodic care:

_____

_____

Signature of Health Care Provider: _____ Date: _____

PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT

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

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

U.S. Department of Labor
Wage and Hour Division

DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR; RETURN TO THE PATIENT

OMB Control Number: 1235-0003
Expires: 8/31/2021

SECTION I: For Completion by the EMPLOYER

INSTRUCTIONS to the EMPLOYER: The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA protections because of a need for leave due to a serious health condition to submit a medical certification issued by the employee's health care provider. Please complete Section I before giving this form to your employee. Your response is voluntary. While you are not required to use this form, you may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. §§ 825.306-825.308. Employers must generally maintain records and documents relating to medical certifications, recertifications, or medical histories of employees created for FMLA purposes as confidential medical records in separate files/records from the usual personnel files and in accordance with 29 C.F.R. § 1630.14(c)(1), if the Americans with Disabilities Act applies, and in accordance with 29 C.F.R. § 1635.9, if the Genetic Information Nondiscrimination Act applies.

Employer name and contact: _____

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

Employee's essential job functions: _____

_____

Check if job description is attached:

SECTION II: For Completion by the EMPLOYEE

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

Your name: _____
First Middle Last

SECTION III: For Completion by the HEALTH CARE PROVIDER

INSTRUCTIONS to the HEALTH CARE PROVIDER: Your patient has requested leave under the FMLA. Answer, fully and completely, all applicable parts. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can; terms such as "lifetime," "unknown," or "indeterminate" may not be sufficient to determine FMLA coverage. Limit your responses to the condition for which the employee is seeking leave. Do not provide information about genetic tests, as defined in 29 C.F.R. § 1635.3(f), genetic services, as defined in 29 C.F.R. § 1635.3(e), or the manifestation of disease or disorder in the employee's family members, 29 C.F.R. § 1635.3(b). Please be sure to sign the form on the last page.

Provider's name and business address: _____

Type of practice / Medical specialty: _____

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

PART A: MEDICAL FACTS

1. Approximate date condition commenced: _____

   Probable duration of condition: _____

   Mark below as applicable:
   Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility?
   ___No ___Yes. If so, dates of admission:

   _____

   Date(s) you treated the patient for condition:

   _____

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

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

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

   _____

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

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

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

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

   _____

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

   _____

   _____

   _____

   _____

   _____

   _____

   _____

PART B: AMOUNT OF LEAVE NEEDED

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

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

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

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

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

   _____

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

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

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

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

   _____

   _____

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

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

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

ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER.

_____

_____

_____

_____

_____

_____

Signature of Health Care Provider **Date**

PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT

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

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

U.S. Department of Labor
Wage and Hour Division

DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR; RETURN TO THE PATIENT.

OMB Control Number: 1235-0003
Expires: 8/31/2021

SECTION I: For Completion by the EMPLOYER

INSTRUCTIONS to the EMPLOYER: The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA protections because of a need for leave to care for a covered family member with a serious health condition to submit a medical certification issued by the health care provider of the covered family member. Please complete Section I before giving this form to your employee. Your response is voluntary. While you are not required to use this form, you may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. §§ 825.306-825.308. Employers must generally maintain records and documents relating to medical certifications, recertifications, or medical histories of employees' family members, created for FMLA purposes as confidential medical records in separate files/records from the usual personnel files and in accordance with 29 C.F.R. § 1630.14(c)(1), if the Americans with Disabilities Act applies, and in accordance with 29 C.F.R. § 1635.9, if the Genetic Information Nondiscrimination Act applies.

Employer name and contact: _____

_____

SECTION II: For Completion by the EMPLOYEE

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

Your name: _____
First Middle Last

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

Relationship of family member to you: _____

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

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

_____

_____

_____

_____ ____ _____
Employee Signature Date

CONTINUED ON NEXT PAGE

SECTION III: For Completion by the HEALTH CARE PROVIDER

INSTRUCTIONS to the HEALTH CARE PROVIDER: The employee listed above has requested leave under the FMLA to care for your patient. Answer, fully and completely, all applicable parts below. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can; terms such as "lifetime," "unknown," or "indeterminate" may not be sufficient to determine FMLA coverage. Limit your responses to the condition for which the patient needs leave. Do not provide information about genetic tests, as defined in 29 C.F.R. § 1635.3(f), or genetic services, as defined in 29 C.F.R. § 1635.3(e). Page 3 provides space for additional information, should you need it. Please be sure to sign the form on the last page.

Provider's name and business address:_____

Type of practice / Medical specialty: _____

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

PART A: MEDICAL FACTS

1. Approximate date condition commenced: _____

   Probable duration of condition: _____

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

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

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

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

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

   _____

   _____

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

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

_____

_____

_____

_____

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

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

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

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

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

   _____

   _____

   _____

   _____

   _____

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

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

   _____

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

   _____

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

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

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

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

   _____

   _____

   _____

   _____

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

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

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

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

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

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

_____

_____

_____

_____

ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER.

_____

_____

_____

_____

_____

_____

_____ _____

Signature of Health Care Provider **Date**

PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT

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

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

U.S. Department of Labor

Wage and Hour Division

OMB Control Number: 1235-0003
Expires: 8/31/2021

SECTION I: For Completion by the EMPLOYER

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

Employer name: _____

Contact Information: _____

SECTION II: For Completion by the EMPLOYEE

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

Your Name: _____
First Middle Last

Name of military member on covered active duty or call to covered active duty status:

_____
First Middle Last

Relationship of military member to you: _____

Period of military member's covered active duty: _____

A complete and sufficient certification to support a request for FMLA leave due to a qualifying exigency includes written documentation confirming a military member's covered active duty or call to covered active duty status. Please check one of the following and attach the indicated document to support that the military member is on covered active duty or call to covered active duty status.

A copy of the military member's covered active duty orders is attached.

Other documentation from the military certifying that the military member is on covered active duty (or has been notified of an impending call to covered active duty) is attached.

I have previously provided my employer with sufficient written documentation confirming the military member's covered active duty or call to covered active duty status.

PART A: QUALIFYING REASON FOR LEAVE

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

_____

_____

_____

_____

2. A complete and sufficient certification to support a request for FMLA leave due to a qualifying exigency includes any available written documentation which supports the need for leave; such documentation may include a copy of a meeting announcement for informational briefings sponsored by the military; a document confirming the military member's Rest and Recuperation leave; a document confirming an appointment with a third party, such as a counselor or school official, or staff at a care facility; or a copy of a bill for services for the handling of legal or financial affairs. Available written documentation supporting this request for leave is attached.

Yes ☐ No ☐ None Available ☐

PART B: AMOUNT OF LEAVE NEEDED

1. Approximate date exigency commenced: _____

Probable duration of exigency: _____

2. Will you need to be absent from work for a single continuous period of time due to the qualifying exigency?

Yes☐ No☐

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

_____

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

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

_____

_____

_____

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

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

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

PART C:

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

Name of Individual: _____ Title: _____

Organization: _____

Address: _____

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

Email: _____

Describe nature of meeting: _____

_____

_____

_____

_____

_____

_____

_____

PART D:

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

Signature of Employee _____ Date _____

PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT

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

NEBRASKA
ACCOUNTABILITY AND
DISCLOSURE COMMISSION
11th Floor, State Capitol
P.O. Box 95086
Lincoln, NE 68509
(402) 471-2522

BEFORE COMPLETING THIS FORM
READ THE FILING REQUIREMENTS
ON PAGE 3

CONTRACTUAL INTEREST STATEMENT

NADC FORM C-3

POSTMARK DATE	
MICROFILM NUMBER	

OFFICE USE ONLY

- A local officer with an interest in any contract to which his or her governing body or anyone for its benefit is a party must disclose the interest on the record of the governing body responsible for approving the contract, or in writing by filing this form.
- File with the person charged with keeping records for the governing body involved in the contract **prior** to official consideration of the contract.
- Persons who fail to disclose their interests or otherwise do not comply with the law are subject to penalties.

ITEM 1 **YOUR NAME ADDRESS AND PHONE NUMBER**

Name _____ Telephone No. _____
Last First Middle

Address _____ _____ _____
STREET ADDRESS OR RURAL ROUTE City STATE ZIP CODE

ITEM 2 **OFFICE OR POSITION, ADDRESS, PHONE, TERM OF OFFICE**

Office or Position: _____ Term: _____

Name of City, County, District, Village, etc: _____

Address _____ Phone _____

ITEM 3 **CONTRACT IN WHICH YOU HAVE AN INTEREST**

A. Names of Contracting Parties: _____

B. Body Which Will Consider the Contract: _____

C. Date Set for Consideration: _____

D. Subject Matter and Basic Terms: _____

ITEM 4	NATURE AND EXTENT OF YOUR INTEREST IN THE CONTRACT AND AMOUNT OF CONTRACT (Use ITEM 5, CONTINUATION, if necessary)

ITEM 5	CONTINUATION

(Signature) (Date)

General Information - Filing Requirements

I. Who Must File:

A local officer with an interest in a contract to which his or her governing body or anyone for its benefit is a party must disclose the interest on the record of the body responsible for approving the contract, or in writing by filing this form.

II When to File:

An officer must declare his or her interest in a contract and the nature and extent of the interest **prior** to official consideration of the contract. The information concerning the contract listed in ITEM 3 of this form must be provided to the person in charge of keeping records of the governing body within 10 days after the contract is signed by both parties.

III. Where to File:

File with the person charged with keeping records for the governing body involved in the contract. For example, members of a County Board of Commissioners file with the County Clerk.

Disclosure of Potential Conflict of Interest by State Executive Branch Officials, Employees, and Others required to file Statements of Financial Interest. If you are disclosing a potential conflict of interest under section 49-1499 of the Accountability Act, use NADC Form C-2, Potential Conflict of Interest Statement.

Disclosure of the Employment of Immediate Family Members. If you are disclosing the employment of an immediate family member, use NADC Form C-4, Employment of Immediate Family Members Disclosure Statement.

An officer has an **interest** in a contract when the officer or his or her spouse, parent, or child: (a) has a business association as defined in sections 49-1408 and 49-14,103.01(5) with the business involved in the contract, or (b) will receive a direct pecuniary fee or commission as a result of the contract. An officer interested in a contract with his or her governing body may not: (1) vote on the matter of granting the contract, or (2) act for the governing body as to inspection or performance under the contract.

An **open account** established for the benefit of any governing body with a business in which an officer has an interest is considered a contract subject to disclosure requirements.

For purposes of contractual interest conflicts, as covered by section 49-14,103.01, ownership of less than five percent of the outstanding shares of a corporation shall not constitute an interest subject to disclosure.

Receiving deposits, cashing checks, and buying and selling warrants and bonds of indebtedness of a governing body by a financial institution is **not** considered a contract.

Any governing body as defined below may prohibit officers from having an interest in contracts over a specific dollar amount. A governing body may also exempt from disclosure requirements contracts for one hundred dollars or less in which an officer of the body has an interest.

Definitions

Officer means a member of the board of directors of a natural resources district, a member of any board or commission of any county, school district, city or village which spends and administers its own funds, who is dealing with a contract made by such board or commission, and any elected county, school district, educational service unit, city, or village official, and a member of any board of directors or trustees of a district hospital as provided by the Nebraska Local hospital District Act or a county hospital as provided by sections 23-343 to 23-343.19. Officer shall **not** mean volunteer firefighters or ambulance drivers with respect to their duties as firefighters or ambulance drivers.

Governing Body means the board of directors of a natural resources district, the board of supervisors or the board of commissioners of any county, a school district board, the board of an educational service unit, the city council of a city, the village board of a village, the board of directors or trustees of a district hospital as provided by the Nebraska Local Hospital District Act, sections 23-343.20 to 23-343.47, or a county hospital as provided by sections 23-343 to 23-343.19, or any board or commission of any county, school district, city or village which spends and administers its own funds.

Business means any corporation, partnership, sole proprietorship, firm, enterprise, franchise, association, organization, self-employed individual, holding company, joint stock company, receivership, trust, activity or entity.

Business with which you are associated means a business: (1) in which you are a partner, director or officer; or (2) in which you or a member of your immediate family is a stockholder of closed corporation stock worth $1,000 or more at fair market value or which represents more than a 5 percent equity interest, or is a stockholder of publicly traded stock worth $10,000 or more at fair market value or which represents more than a 10 percent equity interest.

For purposes of contractual interest conflicts, as covered by section 49-14,103.01, ownership of less than five percent of the outstanding shares of a corporation shall not constitute an interest subject to disclosure.

Statutory Authority: Section 49-14,103.01 R.S. Supp., 1987, and sections 49-14,103.02 to 49-14,103.07 R.S. Supp., 1986.

Return to Work Form

To be completed by healthcare provider prior to returning to work.

_____ has been treated by me for _____
(Patient) (Condition)

I have examined the Patient named above and reviewed the Patient's job description, if provided. I certify that in accordance with this patient's physical capability (check all that apply)

Restrictions

□ Patient may resume work immediately, no restrictions
□ Patient may resume work immediately with the following restrictions:
- □ Sedentary work (sitting, occasional walking, standing, lifting less than 10 lbs.)
- □ Light work (lifting less than 20 lbs.)
- □ Medium work (lifting less than 50 lbs.)
- □ Heavy work (lifting less than 100 lbs.)
- □ Other*:_____
- □ Other*:_____

**If "Other" is selected, on a separate sheet of paper address the details of the restriction, the particular duties which are affected, why they are affected, and any accommodations which would allow the employee to perform the duties.*

Hours/Shifts

□ He/She is released to work
- □ Hours per day: _____
- □ His/her normal shift

□ He/She may return to work at full duty on _____(date)
□ He/She has a return appointment on _____ (date) at _____(time)

Other Medically Significant Information the Employer Should Know:

_____
_____
_____
_____

_____ _____
Healthcare Provider's Signature Date

_____ _____
Printed Name of Healthcare Provider Telephone Number

_____
_____ _____
Address Type of Practice

Assignment Letter

Date

Dear _____:

This letter is to inform you that the school district's administration has assigned you to perform the extra duties indicated below for the _____ school year. You will receive extra duty pay for each of these assignments as provided for in the district's negotiated agreement with the local education association. This extra duty salary will be paid in 12 equal installments beginning with the first regular pay period of the contract year in which the services will be rendered.

Assignment	**Annual Extra Duty Pay**	**Amount of Extra Duty Pay per Pay period**

Your extra duty assignment will begin on or about June 1 and will conclude on or about May 31 of the upcoming school year. Your extra duty pay will begin about September 1 and will conclude on or about August 30 of the upcoming school year.

As a full-time certificated employee, it is anticipated that you will work more than 1100 hours based solely on your teaching assignment. In addition to your regular teaching duties, you will render service hours toward the performance of each of your listed extra duty assignments throughout the entirety of the contract year. You will dedicate time each month of the contract toward fulfilling your extra duty assignment. In the exercise of your professional judgment, this time should include

tasks such as: continuously reviewing best practices for coaching/sponsoring your extra duty; determining any off-season professional development or meetings which you should attend; determining any pre-season or pre-event camps or activities which students should attend; supervising selected pre-season camps or activities; creating records and completing paperwork related to the extra duty; communicating with selected media outlets about the extra duty; training and preparing students prior to the beginning of the competition/activity/event schedule; reviewing or planning the competition/event schedule; studying film, selecting music or scripts, designing sets and costumes, arranging choreography and otherwise preparing for the competition or season; scheduling student meetings and events; actively supervising participating students before, during and after the season/event; study of best practices in sportsmanship and student character growth; and any other identified duties: _____.

In the event you are assigned an extra duty assignment after August 1 of the school year in which the activity occurs, the district will report the extra duty pay and hours to the Nebraska State Retirement System beginning in the month when you undertake your assignment.

In the event your overall employment and/or your extra duty assignment is terminated prior to the end of the school year, you will not be paid any remaining amounts for extra duty service and those hours will not be reported to the Nebraska State Retirement System.

If you have any questions about your assignments, please contact my office.

Sincerely,

Superintendent of Schools

I acknowledge receipt of this assignment letter on _____, 202_.

_____

Teacher

[School District Letterhead]

[Date]

[Name]
[Address]
[City, State Zip]

Dear [Name]:

In your application for employment, you indicated that you qualify under Nebraska law for a Veterans Preference, and you supplied the necessary paperwork to substantiate your eligibility. After applying the requirements of the law and assessing the qualifications of all applicants, we will not be offering you the position.

There are no appeal rights at the school district level. However, if you would like to discuss your rights, including any rights to appeal, you should consult your regular attorney or contact the Nebraska Department of Labor. Their contact information and more information on Nebraska's Veterans Preference can be found on their website: www.dol.nebraska.gov.

Sincerely,

[Superintendent Name], Superintendent