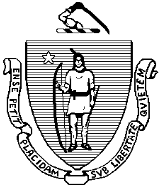


THE COMMONWEALTH OF MASSACHUSETTS
EXECUTIVE OFFICE FOR ADMINISTRATION AND FINANCE
HUMAN RESOURCES DIVISION
ONE ASHBURTON PLACE, BOSTON, MA 02108

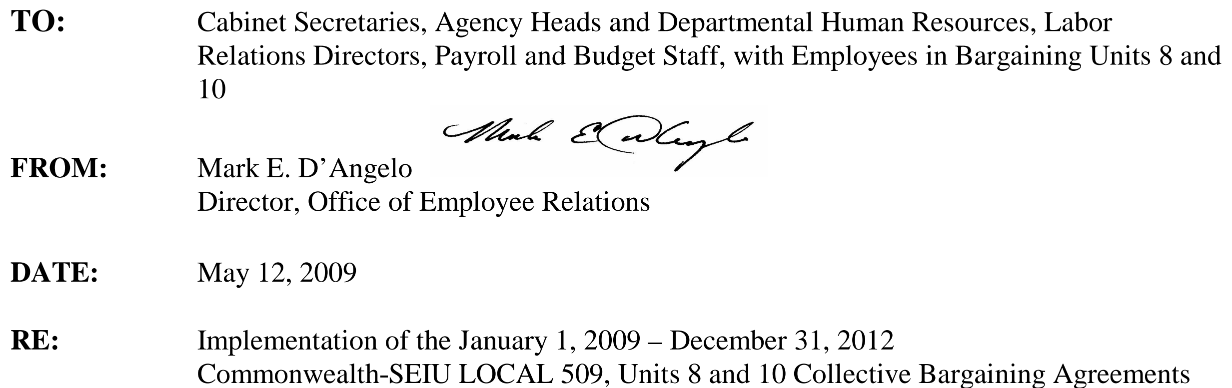
DEVAL L. PATRICK
Governor

TIMOTHY P. MURRAY
Lieutenant Governor

LESLIE A. KIRWAN
Secretary

PAUL DIETL
Chief Human Resources Officer

MEMORANDUM



TO: Cabinet Secretaries, Agency Heads and Departmental Human Resources, Labor Relations Directors, Payroll and Budget Staff, with Employees in Bargaining Units 8 and 10

FROM: Mark E. D'Angelo
Director, Office of Employee Relations

DATE: May 12, 2009

RE: Implementation of the January 1, 2009 – December 31, 2012
Commonwealth-SEIU LOCAL 509, Units 8 and 10 Collective Bargaining Agreements

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On February 12, 2009, the Commonwealth of Massachusetts, through the Human Resources Division, signed labor agreements with SEIU, Local 509, Units 8 and 10, for the period January 1, 2009 to December 31, 2012. This memorandum authorizes the implementation of the **non-economic provisions** of the new agreements **effective February 12, 2009, except as noted below.**

This implementation memorandum will be posted on the HRD website (see link below). However, the new agreements, salary charts and an economic implementation memorandum authorizing the incremental cost increases, will be posted on HRD's website (www.hrd.state.ma.us), as soon as administratively feasible once funding has been authorized.

Summary of Changes and Policy Information

The following changes do not apply to employees in bargaining units 8 and 10, in confidential positions.

Article 6A (New Article): Mutual Respect
The Commonwealth and the Union agree that mutual respect between and among managers, employees, co-workers and supervisors is integral to the efficient conduct of the Commonwealth's business. Behaviors that contribute to a hostile, humiliating or intimidating work environment, including abusive language or behavior, are unacceptable and will not be tolerated. (Please see the Memorandum of Understanding on the HRD website for details).

Article 8, Section 8.1 D (2&3): Sick Leave
Increase of sick in family leave days from thirty (30) to sixty (60) days.
Increase of adoption related use of sick leave days from thirty (30) to sixty (60) days.

Article 8, Section 4: Bereavement Leave
Upon provision of satisfactory evidence to the Appointing Authority of the death of a spouse or child, employee is entitled to a maximum of seven (7) paid leave days to be used at their option within thirty (30) days of the death.

Article 8, Section 8.7. 2 B(1): Family and Medical Leave
Effective January 4, 2009, upon submission of satisfactory medical evidence, employees may be granted on a one time basis, twenty-six (26) weeks of non-intermittent FMLA leave for an existing catastrophic illness.

Article 14: Reassignments
The Department of Early Education and Care, Mass. Rehab Commission and MassHealth will participate in a two (2) year job swapping pilot program for employees who commute long distances and work in the same agency and job title/functions, but have disparate work locations. *When processing a job swap in HR/CMS, agencies should enter an action of 'transfer' with a reason code of 'Non Civil Service – Same Dept.'* (Please see the Memorandum of Understanding on the HRD website for more details).

Article 18: Recall
An employee who is laid off during the term of the contract shall remain on the recall roster for three (3) years. Effective January 1, 2012, a laid off employee shall remain on the recall list for two (2) years.

Article 19, Section 11 Educational Incentive
A labor-management committee shall identify suitable parameters for employees to become eligible for this incentive, by discipline/job title, effective July 1, 2009.

Article 20: Safety and Health
Parties agree to establish a program to monitor air quality at new and existing worksites. The parties agree to negotiate over the specific provisions of such a protocol within 60 days from date of ratification.

Article 29: Section 12 (new) Professional Standards
A labor management committee shall develop procedures by which management can verify that employees who use their automobiles on Commonwealth business, have valid driver licenses and legally registered and inspected vehicles. These procedures shall be effective July 1, 2009.

Side Letter on GPS:
The Commonwealth will not require employees to use GPS devices for the primary purpose or use of tracking employee attendance.

FMLA Leave:
At the discretion of the Appointing Authority, FMLA leaves may be extended or renewed beyond the 26 weeks otherwise provided for in the agreement.

FMLA Leave Request Forms:
The Department of Labor form numbers WH-380-E and WH-380-F for requesting FMLA benefits individual and family member FMLA leave **(Appendices G-1 and G-2)**.

03/07 Credible Service
Appointing Authority shall notify employees at their time of hire, on a form agreed to by the parties, that they may request credit for prior service as a 03/07. Employees will have one (1) year from date of notification to request said credit. If employee fails to request credit within the allotted one (1) year, they shall only be eligible to receive creditable service on a prospective basis.

Sick Leave Bank
A labor/management committee will be formed to study the use and administration of sick and extended illness leave banks.

DOC teachers
The parties agree to continue discussions regarding the schedules of both academic and vocational teachers at the Department of Correction.

Side Letter on DCF Promotions:
The parties agree to reopen discussions on promotional opportunities within DCF on or after January 1, 2010.

APPENDIX G-1

CERTIFICATION OF HEALTH CARE PROVIDER FOR EMPLOYEE'S SERIOUS HEALTH CONDITION (FMLA)

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, recertification, 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.

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. 20 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. 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):

____

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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:

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Signature of Health Care Provider **Date**

APPENDIX G-2

CERTIFICATION OF HEALTH CARE PROVIDER FOR FAMILY MEMBER'S SERIOUS HEALTH CONDITION (FMLA)

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, recertification, 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.

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:
____

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

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. 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; _____ day(s) 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:

____

____

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ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER:

____

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______________________________________ ___________________________________
Signature of Health Care Provider Date