Request to Place an Item on the Agenda

Name: _____

Address: _____

Telephone number: _____

Name of school children attend, if applicable: _____

Group represented: _____

Check if request was submitted to: ☐ Superintendent ☐ Board Chairperson

Conferred with following administrators (names): _____

_____

_____

Description of Issue: _____

_____

_____

_____

_____

_____

Specific Action Requested: _____

_____

_____

_____

_____

Check if you are: ☐ Board Member ☐ District Employee ☐ Community Member

All requests for items to be placed on the agenda must be submitted to the Superintendent prior to the Board meeting as specified in Board Policy 01.45. Items submitted shall require prior approval of the Superintendent within five (5) business days of the Board meeting.

Hiring

The following procedures shall apply in the recruitment, selection, and employment of all classified and certified personnel hired in the District.

RECRUITMENT

Recruiting shall be the responsibility of the Superintendent/designee. Efforts shall be made to recruit a quality staff to include, but not be limited to:

1. Working through placement bureaus of regional and state colleges and universities;
2. Working with state educational associations and the state department of education; and
3. Advertising through appropriate media.

POSTING

Vacancies shall be posted in the Central Office, in each school building during the school year, and in the following as appropriate:

- boone.kyschools.us~~Local and/or state newspapers~~,
- Predetermined locations in the community,
- Social media~~Professional publications~~, and/or
- Campus recruiting offices.

NOTE: Districts are required to post all certified vacancies on the Kentucky Department of Education's web site.

All postings at the local level shall be made within five (5) working days of each certified vacancy opening. The closing date for receiving applications shall be listed when vacancies are posted.

CERTIFIED VACANCIES

The Superintendent/designee shall notify the Commissioner of Education of the vacancy at least fifteen (15) days prior to filling the position. When such a vacancy needs to be filled in fewer than fifteen (15) days to prevent disruption of necessary instructional or support services, a waiver may be requested from the Commissioner of Education. If the waiver is approved, the appointment shall not be made until the person selected has been approved by the Commissioner of Education.

APPLICATIONS

Completed applications should be filed in the Superintendent's office and accompanied by transcripts and certificates, as appropriate.

All employment applications shall be submitted electronically.

~~The Superintendent/designee shall review each application for completeness and shall send a notice to each applicant indicating (a) the date of the review and (b) any additional materials requested.~~

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Hiring

SELECTION FACTORS

The Superintendent/designee shall screen applicants based on the following factors:

1. Certification (when required for the position)
2. Educational background
3. Previous work experience
4. Recommendations
5. Personal dispositions~~characteristics~~ exhibited during the interview process:
   a. Ability to communicate
   b. Ability to work cooperatively with others
   c. Applicant's educational philosophy
   d. Knowledge of work area or subject matter
6. Results from required testing

EMPLOYMENT

For SBDM schools, hiring shall follow statutory guidelines and the provisions of Policy 02.4244, and the Superintendent shall complete the hiring process. Decisions on Central Office and District-wide personnel shall be made by the Superintendent/designee. The Superintendent shall inform the Board of the appointment of all personnel.

CONTRACT

Personnel hired by the Superintendent shall be notified of their contractual obligations by letter. The contract must be signed and returned to the Personnel Office. If not returned the contract may be considered null and void.

Certified Staff Applicant Checklist

Name _____

Date _____

Sex _____ Race _____

School & Grade(s) _____

Subject Teacher _____

Rank _____ Years Exp. _____

Full-time _____ Part-time _____ (Ex.2, .5, .7)

Previous School District _____

Hire Date _____

I verify that I have received a copy of and reviewed the Certified Employee Handbook of Boone County Schools.

_____

Employee Signature

Date of Signature _____

Generalist Completing Orientation:

_____

Date: _____

INFORMATION REVIEWED WITH EMPLOYEE	OFFICE USE ONLY
☐ Sources of Additional Information (nn 2)	☐ Contract
☐ Code of Ethics (nn 3)	☐ KTIP Acknowledgement
☐ COUNTY MISSION STATEMENT (NN 4)	☐ Benefits Appointment
☐ Statement of Confidentiality (p. 5)	☐ Payroll Setup Sheet
☐ Contract	☐ W-4
☐ Nepotism Statement (pg. 8)	☐ K-4
☐ Transfer Application (process review p. 8-10)	☐ I-9
☐ KTIP Packet (Include. Checklist, Letter, Flowchart)	☐ BCEA _____ Application _____ Waiver
☐ Physical Form/TB (p.10)	☐ Sub Finder Setup Sheet
☐ Salary Schedule (pay review p. 11-13)	☐ Social Security Card (copy)
☐ Experience Verification Form	☐ New Hire Form
☐ Payroll Setup Sheet	☐ Worker's Compensation Form
☐ W-4	☐ Internet Policy Form
☐ State Withholding Form (KY-K-4, IN-WH-4, OH-IT-4)	☐ Nepotism Statement
☐ I-9	☐ Fingerprint Card
☐ Social Security Card (copy)	☐ $24.00 Check
☐ BCEA Packet/Waiver Acknowledgement	☐ Criminal Record _____ Sent _____ Rec'd
☐ Direct Deposit Form	AOC _____ Sent _____ Rec'd
☐ Benefits Appointment	☐ Experience Verification _____ Sent _____ Rec'd
☐ Worker's Compensation Information	☐ Completed Physical/TB
☐ Sub Finder Instruction Guides	☐ Bloodborne Pathogens Completed

Certified Staff Applicant Checklist

☐ Sub Finder Setup Sheet	☐ Certificate (Type _____) (Ex. Provisional, Emergency, SOE, etc.)
☐ New Hire Form	_____ Generalist Signature
☐ Non-discrimination Policy (p.26)	Date File Complete _____
☐ Harassment/Discrimination Procedures (p. 27-29)	
☐ Political Campaigning (p. 32)	
☐ Internet Use Policy	
☐ Drug-Free Work Place (p. 32)	
☐ Bloodborne Pathogens Information (p.35-36)	
☐ School Calendar	
☐ Map of School District	
☐ Fingerprint Card/$24.00 Fee	
☐ Letter from Cabinet for Health and Family Services stating that there are no findings of substantiated child abuse or neglect on record (applicants hired on or after April 4, 2018	

PERSONNEL 03.121-AP.24

Change in Rank

Complete and submit this form to the Superintendent by August 31 of the current school year. Attach documentation verifying your change in rank/licensure.

EMPLOYEE'S NAME _____

SCHOOL/WORK LOCATION _____

IMMEDIATE SUPERVISOR'S NAME _____

My rank/licensure will change from _____

to _____,

effective for the fall term of the _____ *school year. Attached is the required documentation to verify my rank change.*

TEACHERS ONLY

☐ *National Board Certification is pending. Pursuant to policy 03.121, I am providing this notice prior to September 15 in the event a rank-related increase in salary is indicated.*

_____ _____

Employee's Signature ***Date***

_____ _____

Superintendent's Signature ***Date***

NOTE: Before salary adjustments can be made, documentation verifying change in rank must be received by the Superintendent and on file at the Human Resource Office by September 15.

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Workers' Compensation Leave Notification ~~& Sick Leave Waiver~~

Part I: (Must be completed by employee) PRINT NEATLY

The following employee has been injured on the job and has filed a Workers' Compensation claim and hereby gives notice of accident and absence from his/her position. Medical and indemnity (lost wage) benefits may be provided to the employee who has a work-related injury. The benefits provided for work related injuries vary depending on the specific facts and circumstances of each claim. The employee understands that he/she will not be paid by Boone County Schools while absent, and the following conditions apply to approved Workers' Compensation Claims:

- 0-7 days – No indemnity (lost wage) benefits and employee must decide to use or not use sick/personal days during first 7 days of injury
- Greater than 7 days – Indemnity (lost wage) benefits start on the 8th day
- Greater than 15 days –Indemnity (lost wage) benefits start from the first day absent after initial date of injury

Name	Employee ID:
Phone No.	Injury Date:
Address	School/Location
City/State/Zip	Position

First full day of absence:	Anticipated return-to-work date:
Next doctor's visit:	Elected number of sick days to use:

I certify that all information on this application is true, and that I will abide by Board Policy and all state and federal regulations governing Workers' Compensation. According to federal guidelines, I understand that my workers' compensation absence runs concurrently with FMLA. I also understand that my benefits, including health insurance, will be terminated at the end of 12 weeks (with the exception of KRS 161-155). I am aware that unpaid days resulting from my workers' compensation injury will affect my annual retirement service credit and annual pay increases.

Employee Signature	Date

NOTE: You must notify Human Resources upon returning from your workers' compensation leave of absence or your pay and benefits may be impacted. You must submit a doctor's release in order to return to work.

Part II: (To be completed by Human Resources):

Received by:	Date

The Boone County Schools provide equal educational/employment opportunities.

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Workers' Compensation Leave Notification

YOUR RIGHTS UNDER THE FAMILY AND MEDICAL LEAVE ACT OF 1993

FMLA requires covered employers to provide up to 12 weeks of unpaid, job-protected leave per school year to "eligible" employees for certain family and medical reasons (days do not have to be consecutive). Employees are eligible if they have worked for a covered employer for at least one (1) year, and for 1,250 hours over the previous 12 months, and if there are at least 50 employees within 75 miles.

REASONS FOR TAKING LEAVE

Unpaid leave must be granted for any of the following reasons:

1. For the birth and care of an employee's newborn child , or for placement of a child with the employee for adoption or foster care;
2. To care for the employee's spouse, child or parent who has a serious health condition, as defined by federal law;
3. For an employee's own serious health condition, as defined by federal law, that makes the employee unable to perform the employee's job;
4. To address a qualifying exigency (need) defined by federal regulation arising out of the active duty or call to active duty of a covered family member (spouse, son, daughter, parent or next of kin) who serves in a reserve component or as an active or retired member of the Regular Armed Forces or Reserve in support of a contingency operation; and
5. To care for a covered family member (spouse, son, daughter, parent or next of kin) who has incurred an injury or illness in the line of duty while on active duty in the Armed Forces that has rendered or may render the family member medically unfit to perform duties of his/her office, grade, rank or rating.

At the employee's or employer's option, certain kinds of paid leave may be substituted for unpaid leave.

ADVANCE NOTICE AND MEDICAL CERTIFICATION

The employee may be required to provide advance leave notice and medical certification. Taking of leave may be denied if requirements are not met.

The employee ordinarily must provide 30 days advance notice when the leave is "foreseeable."

An employer may require medical certification to support a request for leave because of a serious health condition and may require second or third opinions (at the employer's expense) and a fitness for duty report to return to work.

JOB BENEFITS AND PROTECTION

For the duration of FMLA leave, the employer must maintain the employee's health coverage under any "group health plan", as long as the employee pays premiums that are his/her responsibility.

Upon return from FMLA leave, most employees must be restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms.

The use of FMLA leave cannot result in the loss of any employment benefit that accrued prior to the start of an employee's leave.

UNLAWFUL ACTS BY EMPLOYERS

FMLA makes it unlawful for any employer to:

- Interfere with, restrain, or deny the exercise of any right provided under FMLA;
- Discharge or discriminate against any person for opposing any practice made unlawful by FMLA or for involvement in any proceeding under or relating to FMLA.

ENFORCEMENT

The U.S. Department of Labor is authorized to investigate and resolve complaints of violations.

An eligible employee may bring a civil action against any employer for violations.

FMLA does not affect any Federal or State law prohibiting discrimination or supersede any State or local law or collective bargaining agreement which provides greater family or medical leave rights.

FOR ADDITIONAL INFORMATION

Contact the nearest office of the Wage and Hour Division, listed in most telephone directories under U.S. Government, Department of Labor.

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Part I (To be completed by employee:

The following employee has been injured on the job and has filed a Workers' Compensation claim and hereby gives notice of accident and absence from his/her position. The employee understands that he/she will not be paid by Boone County Schools unless sick days are used while absent. Workers' Compensation Sick Leave Waiver form must be completed if sick days are used.

The following conditions apply to approved Temporary Total Disability Workers' Compensation Claims:

- 0-7 days off work – No pay from Workers' Compensation
- Greater than 7 days off work – Workers' Compensation pay starts on the 8th day
- Greater than 15 days off work – Workers' Compensation is paid from the initial date of injury

Name: _____

Street: _____ **City** _____ **State** _____ **Zip** _____

Position: _____ **School/Location:** _____

- **Date of Injury**: _____
- **Check one of the following in regards to the time away from work:**
  - Did not miss any time from work.
  - Received treatment on the date of injury but returned the next work day.
  - Will not be working for the following period of time:
    - First Full Day of Absence: _____
    - Anticipated return-to-work date: _____
    - Next doctor's visit: _____
    - Other (please explain): _____
- **Did you use any sick days? If yes, how many**? _____

I certify that all information on this application is true, and that I will abide by Board Policy and all state and federal regulations governing Workers' Compensation. According to federal guidelines, I understand that my benefits will be terminated at the end of 12 weeks of FMLA unpaid leave (with the exception to KRS 161.155)

Unpaid leave days may affect retirement credit and annual pay increases.

Employee Signature: _____ **Date of Signature:** _____

Part 2 (To be completed by Principal/Supervisor):

- If substitute employee is needed, contact the SubFinder Office at 282-3689

Principal/Supervisor: _____ **Date:** _____

Part 3 (To be completed by District Office):

Received by: _____ **Date:** _____

PERSONNEL 03.1241 AP.2

- CERTIFIED PERSONNEL -

Return to Work Forms

District provides a Return to Work Program to provide employees with an opportunity to continue as valuable members of our team while recovering from a work related injury. Additional information about the program may be obtained from the Central Office.

ACKNOWLEDGEMENT AND AGREEMENT OF TRANSITIONAL EMPLOYMENT OFFER

Date: _____

Employee: _____

Employer Representative: _____

A transitional job assignment/modified duty position is being offered to me by my employer.

I further understand that this job is a temporary job not to exceed a ninety (90) day period, and my job performance and need for modified duty will be evaluated on a continuing basis. I understand that I will be required to follow all dress codes and rules of my department. The department director will assign working hours and workdays. If released to regular duty status by a treating physician before 90 days, it is my understanding that I will return to my regular job duties.

As a part of this Acknowledgment and Agreement, I understand and expressly agree that I will not exceed any medical restrictions imposed by my treating physician 24 hours a day. I further agree that these restrictions may be made known to my department director and other employees of the department if necessary with such necessity to be determined solely by the department director.

_____ I agree to the modified duty assignment and my starting date is _____.

_____ I acknowledge a modified duty job has been offered to me, but at this time I am declining the offer. I understand that by refusing to participate in the Return to Work Program, I may be subjected to discipline up to and including termination. My benefits through Workers' Compensation may be suspended also.

_____ _____

Employee Signature Date

_____ _____

Witness Date

Return to Work Forms

RETURN TO WORK STATUS REPORT

Date: _____

Name: _____

Date of Injury: _____ Date of treatment: _____

Name of Doctor: _____

Patient Description of Problem:

Diagnosis:

Work or Activity Restrictions:

Lifting Limited to: _____ lbs.

Carrying/Pushing/Pulling Limited to: _____ lbs.

Any other concerns or restrictions: _____

Medication prescribed: _____

Next Appointment Scheduled: _____

_____ _____

Signature of Physician Signature of Patient

PERSONNEL 03.125 AP.21

Travel Request Form (T-1)

Staff Request to Attend Educational Conference, Workshop, Meeting or Student Related Activity

The top of this form must be filled out completely and approved before attending the activity. Once you return, fill out the bottom section (T2) for reimbursement and return to District Office. **TEACHERS:** If you will require a Substitute, complete a "Sub Funding Request Form" and attach.

Name _____ (check one) ☐ Certified ☐ Classified School _____ Grade ____

Activity _____

(Check one) ☐ P. D. Activity ☐ (Non P.D) Student Related Activity

Location of Activity _____ Date(s) of Activity _____

Learning from PD Activity will be shared by: (check one) ☐ Presenting at Faculty Mtg.

☐ Sharing w/Team ☐ Developing & Presenting Workshop ☐ Other (describe) _____

	PO #, if applicable (Attach PO)	Estimated Expense
Mileage- ____@____ Cents per Mile		
Lodging- ____Nights (original receipts required)		
Food (Conference Banquets or max $30/day for overnight travel)		
Registration (original receipts required) (no dues or membership fees)		
Miscellaneous- Please list (original receipts required)		
Total Estimated Expense		

(Check One)

☐ To be funded by School SBDM funds (No District Office authorization required.)

☐ Funding is requested from the District Office source checked below. After this form has been approved by the Principal, submit form to the appropriate District Office Administrator for authorization.

Circle one: Preschool; Title IV; 21st Century; School P.D. Grant; District P.D. Grant; Title II; Advanced Placement; Tech Prep; Perkins Vocational; I.D.E.A.; Title I; KETS; Other (please list) _____

_____ _____

Principal Signature *Date*

_____ _____

District Office Signature *Date*

Budget Account Code _____

COMPLETE BOTTOM PORTION FOR REIMBURSEMENT (AFTER ATTENDING ACTIVITY)

Travel Form-Reimbursement Request (T2)

Professional Development sharing occurred/will occur on _____, Method: _____

	Actual Reimbursable (Personal) Expense
Mileage- ____@____ Cents per Mile	
Lodging- ____Nights (original receipts required)	
Food (Conference Banquets or max $30/day for overnight travel) (Attach meal voucher)	
Registration (original receipts required) (no dues or membership fees)	
Miscellaneous- Please list (original receipts required)	
Total Actual (Personal) Expense	

_____ _____

Principal Signature *Date*

_____ _____

District Office Signature *Date*

PERSONNEL 03.1311 AP.2

- CERTIFIED PERSONNEL -

Transfer Application Form

Select One	Office Use Only
_____ Elementary School _____ Middle School _____ High School	Seniority Date: _____ Dates/Times of Contact: _____ _____ Date Transfer Accepted: _____ Date Transfer Declined: _____ Date Transfer Expired: _____

Date: _____

Name: _____

Address: _____

Home Phone #: (Please provide any additional numbers that may help us contact you.) _____

Present School and Assignment: _____

Subject Areas and Codes listed on Teaching Certificate: _____

*School to which transfer is requested (*Separate form required for each building requested.)

_____

Elementary School (Check the grade level(s) and/or specific position to which you want to transfer.)

	Art		Assistant Principal
	Counselor		Kindergarten
	Librarian		Music
	Physical Education		Preschool
	Principal		Special Education (specify)
-	Early Primary (_____1st / _____2nd)		
	Intermediate (_____4th / _____5th)		Upper Primary (_____2nd / _____3rd)
			Other (specify)

Middle School (Check the position/grade level(s) and list specific subject area(s) to which you want to transfer.)

	Assistant Principal		Counselor
	Librarian		Principal
	Other (specify)		Special Education (specify)
	Unified Arts (specify)		
	Teacher (specify)		Subject Areas:
	_____ Sixth		
	_____ Seventh		
	_____ Eighth		

High School (Check the position and/or list specific subject area(s) to which you want to transfer.)

	Assistant Principal		Counselor
	Librarian		Principal
	Other (specify)		Special Education (specify)
	Teacher		Vice Principal
	Subject Areas: (be as specific as possible)		

Signature _____

The Boone County Schools Provide Equal Educational/Employment Opportunities.

Transfer Form Instructions/Guidelines

Transfers may be filled at any time during the year or during the specified time in response to a particular posting.

Note: Please be aware that teachers on emergency certification or who are part-time (less than 7/10) employees do not have transfer rights.

INSTRUCTIONS:

1. Select One: Elementary School, Middle School or High School
2. Fill out personal information.
3. Check and fill out appropriate lines for position/grade level/subject area to which you request a transfer.
4. Only complete the area that applies to your request. Be as specific as possible.
5. Sign Form. Return to Department of Human Resources. Be sure to keep your copy for at least one (1) year.

GUIDELINES FOR VOLUNTARY AND INVOLUNTARY TRANSFERS:

To ensure that everyone has an equal opportunity to receive the transfers they request, please be aware of the following:

1. The Department of Human Resources will only call for a time period of forty-eight (48) hours before going to the next name on the list.
2. If you are going to be out of town, remember to give the Department of Human Resources all telephone numbers where you can be reached. You may lose your opportunity for a transfer if you cannot be contacted.
3. You will only be offered positions for which you have specifically requested transfers. **"Any subject/any grade" is not an acceptable request.**
4. When contacted, you will have twenty-four (24) hours to make your decision.
5. Remember that transfer requests expire at 12:01 AM on the first day of the school calendar. (example: first day of the school year is 8/18; transfer requests expire at 12:01 AM 8/18) You will need to fill out a new request if you still wish to be considered for any transfers that come available.

Exposure Control Program for Bloodborne Pathogens

Universal precautions must be observed in the clean up of all blood or body fluids. All employees will treat all blood and body fluids as if known to be infected with HIV, HBV, and other bloodborne pathogens. Gloves (non-latex) will be provided for all staff, and CPR masks will be provided for facilities and must be readily accessible to all employees.

No hazardous waste labels or containers should be needed in the schools; however, all custodians will be provided plastic liners for all waste receptacles and disposable non-latex gloves. Universal precautions will be observed in the disposal of all waste products, which will be done daily. Hepatitis B vaccinations will be offered to all designated Class I employees, if they decide not to accept the immunization; a waiver form must be signed by the employee.

No substantial risk of direct exposure to body fluids is anticipated in the school setting; however, if such exposure occurs, universal precautions must be observed and the incident reported immediately to the principal or School District Health Coordinator. The staff members should contact the district's workmen's compensation coordinator for referral concerning post-exposure follow-up.

Blood, OPIM (other potentially infectious materials), OBFW (other body fluids and waste), used gloves, barriers and absorbent materials should be placed in a plastic bag and disposed of in the usual manner. This includes absorbed waste that does not have the potential to release the waste if compressed. Regulated waste---blood, OPIM and OBFW *not* contained in absorbent materials---should be placed in a closed leak-proof container with a bio-hazard label or in a red bag. Double bagging is only required if outside contamination of the original regulated waste container occurs. All contaminated surfaces will be immediately washed with a comparable solution. An appropriate cleaning schedule for rooms where body fluids may be present will be implemented and shall be as frequent as necessary depending on the area of the school, the type of surface to be cleaned, and the amount and type of soil present.

Annually, all personnel who face potential exposure to Bloodborne diseases in the performance of their jobs and for all employees whose assignments change to include potential for exposure will complete the Safe Schools online course. This course will address transmission and symptoms of bloodborne diseases, exposure control plans, how to access copies of the OSHA regulations and exposure control plans, job tasks that involve possible exposure to bloodborne pathogens, universal precautions, use and disposal of personal protective equipment, HBV vaccine benefits, reporting of exposure incidents, post exposure evaluation and follow-up, and hazards.

Employee records will be kept in the Human Resources Department. These will include a record of employee name and social security number, all training sessions attended, immunizations received, and exposure incidents, and follow-up information. Confidentiality shall be maintained for all such records. These records must be kept for 30 years after termination of employment. Training records which must be kept for 3 years.

Exposure Control Program for Bloodborne Pathogens

Class I Employees in this category are routinely exposed to Bloodborne Pathogens (BBP's) in the normal course of performing their jobs.
In-service on BBP's and Universal Precautions (UP's) are required annually.
HBV is offered.

Job Classification:
- School Nurses
- Staff Support Assistants/Health
- Multiple Disabilities Teachers
- Multiple Disabilities Para Educators

Job Classification (cont. – Class I)
- Preschool Teachers
- Preschool Para Educators
- Day Treatment Teachers
- Day Treatment Para Educators
- Custodians
- Teacher/Child Care Center
- Child Care Center Para Educators

Class II Employees in this category **could** be exposed to BBP's in the normal course of performing their jobs.

- In-service on BBP's and Universal Precautions (UP's) are required **annually**.
- Offer HBV **after** an exposure incident takes place.

Job Classification:
- Bus Drivers
- Transportation Aides
- Coaches
- Athletic Directors
- Substitute Staff Support Assistants/Health
- Cheerleading Sponsors
- School Secretaries
- Band Directors
- Substitute Custodians
- Substitute Special Education Para Educators
- Maintenance Personnel
- Teachers
- Principals
- Assistant Principals
- Guidance Counselors

Class III Employees in this category have duties that should **not** include exposure to BBP's.

- In-service on BBP's and Universal Precautions (UP's) are required **annually**.
- Offer HBV if an exposure incident takes place.

Job Classification:
- Staff Support Assistants
- Bus Duty Aides
- Para Educators
- Student Teachers
- Substitute Teachers
- Food Service Personnel
- Mechanics
- Community Education Instructors
- District Office Clerical Personnel
- School Finance Secretaries
- District Administrators
- Drill Team Sponsors

Exposure Control Program for Bloodborne Pathogens

VACCINATION DECLINATION FORM

(29 CFR 1910-1030)

_____ _____
Employee Name Employee ID#

I understand that due to my occupational exposure to blood or other potential infectious materials, I may be at risk of acquiring Hepatitis B Virus (HBV) infection.

If my position is identified as a Class I position according to the Boone County Schools' Exposure Control Program for Bloodborne Pathogens, I have been given the opportunity to be vaccinated with Hepatitis B vaccine, at no charge to myself.

However, I decline the Hepatitis B vaccination at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring Hepatitis B, a serious disease. If, in the future, I continue to have occupational exposure to blood or other potential infectious materials and I want to be vaccinated with Hepatitis B vaccine, I can receive the vaccination series at no charge to me.

If my position is identified as a Class II or III position according to the Boone County Schools' Exposure Control Program for Bloodborne Pathogens, I will be given the opportunity to be vaccinated with Hepatitis B vaccine, at no charge to myself, after an exposure incident takes place.

~~I understand that due to my occupational exposure to blood or other potentially infectious materials, I may be at risk of acquiring Hepatitis B Virus (HBV) infection. I have been given the opportunity to be vaccinated with Hepatitis B vaccine, at no charge to myself.~~

~~However, I decline the Hepatitis B vaccination at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring Hepatitis B, a serious disease. If, in the future, I continue to have occupational exposure to blood or other potential infectious materials and I want to be vaccinated with Hepatitis B vaccine, I can receive the vaccination series at no charge to me.~~

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_____ _____
Employee Signature Date

_____ _____
Facility Representative Signature Date

PERSONNEL 03.221 AP.22

- CLASSIFIED PERSONNEL -

Classified Personnel Checklist

Date _____
Name _____
School _____
Position _____ Full-time _____ Part-time _____
Date of Hire _____

PLEASE INITIAL ITEMS REVIEWED	OFFICE USE ONLY
☐ Fingerprint Card	☐ Physical
☐ I-9	☐ AOC _____ Sent _____ Rec'd
☐ W-4	☐ Criminal Record _____ Sent _____ Rec'd
☐ ESSA Requirements	☐ Letter from Cabinet for Health & Family Services
☐ Payroll/BCCCEA Setup	☐ Bloodborne Pathogens Completed
☐ New Hire Form	☐ CPR/First Aid Scheduled _____
☐ Worker's Compensation Information	☐ CPR/First Aid Completed
☐ CPR/First Aid Requirements	☐ Restraint & Seclusion Training (if applicable)
☐ Hepatitis B Information	☐ Child Abuse Training (if applicable)
☐ Bloodborne Pathogens Information	☐ Worker's Compensation Form
☐ Non-Discrimination Policy	☐ Experience Verification(s)
☐ Drug-Free Workplace	☐ Asbestos Training
☐ Confidentiality Statement	☐ Typing Test Results
☐ Code of Ethics	☐ Ky. Para-Educator Assessment or 48 Credit Hrs. or Associates/Higher Degree
☐ Mission Statement	☐ Social Security Card Copy
☐ School Calendar	☐
☐ Direct Deposit Form	**BUS DRIVERS**
☐ Sources of Additional Information	☐ CDL Copy
☐ Map of School District	☐ Dot Copy
☐ Nepotism Statement	☐ Sent Transportation Copy of Physical, TB, MVR ☐ Date Sent _____
☐ Political Campaigning	☐ MVR _____ State(s)
☐ Physical Form or Electronic Record	☐ DOT 49 C.F.R. 40.25
☐ Personnel Board Policies	**BUS DRIVERS ONLY**
☐ Harassment/Discrimination Procedures	☐ Pre-Employment Drug/Alcohol Consent
☐ Expressed Concern Procedure	☐ MVR Authorization
☐ Change of Assignment Policy	☐ CDL Reimbursement
☐ Change of Assignment Form	☐ Driver Training Compensation
☐ Equal Pay	
☐ Salary Schedule	
☐ Number of Job-Related Experience Forms (to be turned in within 90 days (i.e. 1, 2, 3, etc.)	_____ Employee Signature
☐ Subfinder Registration & Instructions	
☐ Computer Internet Use Policy	

PERSONNEL 03.221-AP.23

Classified Time Sheet

EMPLOYEE _____ EMPLOYEE NUMBER _____

LOCATION _____ OCCUPATION _____

WEEK ENDING _____

	Date	On	Off	On	Off	On	Off	Total Hours	Contract Hours
Mon									
Tues									
Wed									Additional Hours
Thurs									
Fri									
Sat									Shift Differential
Sun									
							Total Hours Worked		

WEEK ENDING _____

	Date	On	Off	On	Off	On	Off	Total Hours	Contract Hours
Mon									
Tues									
Wed									Additional Hours
Thurs									
Fri									
Sat									Shift Differential
Sun									
							Total Hours Worked		

EMPLOYEE'S SIGNATURE _____

PRINCIPAL OR SUPERVISOR'S SIGNATURE _____

Please complete and submit to school Financial Secretary.

PERSONNEL 03.221 AP.24

- CLASSIFIED PERSONNEL -

Overtime Approval Form

FOR PRIOR APPROVAL OF OVERTIME HOURS, COMPLETE THIS FORM AND SUBMIT IT TO THE CENTRAL OFFICE.

Hourly classified employees required to work in excess of forty (40) hours per week will be paid at the rate of 1½ times the regular rate for all hours beyond forty (40) as provided by law. Overtime must be approved in advance by the Superintendent or designee.

Please grant approval for _____
(Employee/Job Title)

to work overtime on _____ at _____
(Date) *(Location)*

The total estimated overtime hours shall not exceed _____

DESCRIPTION OF WORK TO BE PERFORMED: _____

EXPLAIN WHY OVERTIME IS NECESSARY: _____

EXPLAIN HOW OVERTIME WILL BENEFIT DISTRICT: _____

Requested by: _____

Approved by: _____
(Superintendent/Designee)

OVERTIME VERIFICATION

The above listed job has been completed and did not exceed the prior approved number of hours. The above listed employee's actual overtime hours for the completion of this project are _____ hours.

Verified by: _____
(School Level/Principal)
(District Level/Superintendent or Designee)

AFTER VERIFICATION, RETURN THIS FORM TO THE PAYROLL CLERK AT THE CENTRAL OFFICE.

RELATED PROCEDURE:

03.121 AP.23

~~Change in Licensure~~

~~To report a change in licensure, use Procedure 03.121 AP.24.~~

~~PERSONNEL~~ ~~03.2241 AP.2~~

~~- CLASSIFIED PERSONNEL -~~

~~Return to Work Forms~~

~~See existing Procedure 03.124 AP.2 for the appropriate forms.~~

PERSONNEL 03.2311 AP.2
- CLASSIFIED PERSONNEL -

Request for Change of Assignment

NAME DATE

ADDRESS TELEPHONE #

EMPLOYEE #

PRESENT SCHOOL ASSIGNMENT

PRESENT POSITION

SCHOOL & POSITION REQUESTED

SIGNATURE

FILE REQUEST ONLY AFTER POSITION HAS BEEN POSTED
WHITE COPY TO CENTRAL OFFICE DEPARTMENT OF PERSONNEL SERVICES
YELLOW COPY TO PRINCIPAL OF SCHOOL REQUESTED
PINK COPY TO BE KEPT BY APPLICANT

The Boone County Schools Provide Equal Educational/Employment Opportunities

- CLASSIFIED EMPLOYEES -

Employment-Related Staff Development

ONGOING

Classified employees shall be involved in ongoing staff development to improve their performance and the assistance they provide to the instructional program.

~~NEEDS ASSESSMENT~~

~~Supervisors of classified employees shall conduct a prioritized needs assessment which shall be forwarded to the Superintendent/designee or school-based council, as appropriate.~~

SUPERVISORY EMPLOYEES

Classified personnel who hold supervisory positions shall be involved in regularly scheduled meetings with their Central Office Supervisors.

PROFESSIONAL LEAVE

Classified personnel, upon approval by the Superintendent/designee, may be granted professional leave with expenses reimbursed by the Board for the purpose of attending approved meetings/conferences which relate to their areas of employment.

REQUIRED IN-SERVICE

Transportation employees, including bus drivers, and food service employees shall receive in-service training in accordance with the requirements specified in state statutes and regulations.

ALL OTHER CLASSIFIED STAFF

Appropriate training may be provided throughout the school year for custodians/housekeepers, clerical staff members, maintenance personnel, and teacher aides.

RELATED PROCEDURES:

03.225 AP.2
03.29 AP.2

Use of District Credit Card(s)

CREDIT CARD

The Finance Office is the custodian of District credit cards. These credit cards may be used by the Administrative Assistant to Superintendent on behalf of the employees and Board members upon exceptional circumstances to pre-purchase lodging and transportation incurred for out-of-town District/school business. Exceptional circumstances shall be determined on a case-by-case basis, including approved purchases made from vendors that only accept payment by credit card. Use shall be limited to pre-payment of lodging and transportation, as well as exceptional circumstances, when required to be prepaid by credit card by the vendor, and only as approved by the Superintendent/designee. Personal items, spouse/family expenses, etc., are not to be charged to the District credit card even if later reimbursed to the District. Board members shall comply with provisions in Policy 01.821 for the use of credit cards.

SECURING

All individuals using the District purchasing card(s) shall complete the following purchasing card checkout form.

District purchasing cards may not be lent to or used by anyone other than the individual to whom it is issued.

When a hotel requires incidentals be charged to the same credit card used to prepay lodging, the individual shall submit a detailed receipt, in addition to a purchasing card receipt, indicating the date, purpose, and nature of the expense for each claim item. Failure to provide a proper receipt shall make the individual responsible for expenses incurred.*

Name (print)	Purpose	Purchasing Card Name	Purchasing Card #	Date Out	Date In	Signature

*In exceptional cases, the Superintendent or Board may allow a claim without proper receipt. Written documentation explaining the exceptional circumstances shall be considered part of the District's record of claims.

RELATED POLICIES:

01.821, 03.125, 03.225

Daily Playground Safety Checklist

NAME OF INSPECTOR: _____ DATE OF INSPECTION: _____

SCHOOL SITE: _____

Swings	Good Condition	Fair Condition	Poor Condition	Immediate Attention
S Hooks	☐	☐	☐	☐
Hardware Condition	☐	☐	☐	☐
Chain Condition	☐	☐	☐	☐
Seat Condition	☐	☐	☐	☐
Structure Stability	☐	☐	☐	☐
Surfacing	☐	☐	☐	☐

NOTES: _____

Climbing Bars/Structures	Good Condition	Fair Condition	Poor Condition	Immediate Attention
Fall Zone	☐	☐	☐	☐
Catch Points	☐	☐	☐	☐
Hardware Condition	☐	☐	☐	☐
Structure Stability	☐	☐	☐	☐
Surfacing	☐	☐	☐	☐

NOTES: _____

Daily Playground Safety Checklist

Slides	Good Condition	Fair Condition	Poor Condition	Immediate Attention
Fall Protection	☐	☐	☐	☐
Transfer Platform	☐	☐	☐	☐
Hardware Condition	☐	☐	☐	☐
Structure Stability	☐	☐	☐	☐
Surfacing	☐	☐	☐	☐

NOTES:

See-Saws	Good Condition	Fair Condition	Poor Condition	Immediate Attention
Speed Limiting Device	☐	☐	☐	☐
Catch Points	☐	☐	☐	☐
Tire/Bumper Condition	☐	☐	☐	☐
Hardware Condition	☐	☐	☐	☐
Structure Stability	☐	☐	☐	☐
Surfacing	☐	☐	☐	☐

NOTES:

Daily Playground Safety Checklist

Merry-Go-Rounds	Good Condition	Fair Condition	Poor Condition	Immediate Attention
Speed Limiting Device	☐	☐	☐	☐
Catch Points	☐	☐	☐	☐
Structure Stability	☐	☐	☐	☐
Surfacing	☐	☐	☐	☐

NOTES: _____

Other Equipment	Good Condition	Fair Condition	Poor Condition	Immediate Attention
Hardware Condition	☐	☐	☐	☐
Structure Stability	☐	☐	☐	☐
Surfacing	☐	☐	☐	☐

NOTES: _____

OVERALL CLEANLINESS: _____

PUNCTURE POINTS / PROTRUSIONS: _____

PLAYGROUND SUPERVISION: _____

EVENING ACTIVITIES / VANDALISM: _____

_____ _____

Signature of Inspector *Date Submitted*

Use of Automatic External Defibrillators (AED)

NOTE: If an AED is not immediately available, perform CPR until AED arrives on the scene.

PURPOSE OF PROCEDURE:

To provide trained employees of the District with uniform guidelines to follow when responding to sudden cardiac arrest incidents and in intervening with an AED.

DURING SCHOOL HOURS:

1. Assess scene safety. Rescuers are volunteers and are not expected to place themselves at risk in order to provide aid to others. Instead, the scene or environment around a victim must be safe prior to attempting to assist.
2. Determine responsiveness of victim.
3. Activate emergency system:
   a) At any phone, dial 911.
   b) Call main office and alert them to emergency and location of unconscious person.
   c) The primary rescuer~~Main office staff~~ will assign an individual to retrieve the AED and meet responding volunteer(s) at emergency scene.
   d) The office staff will assign someone to wait at the facility entry to direct Emergency Medical Services (EMS) to victim's location.
4. CPR-trained individuals will assess the emergency and, if needed, begin CPR until the AED has arrived:
   a) Open airway.
   b) Check for breathing – if not breathing, or if breathing is ineffective, give two (2) slow breaths. Observe universal precautions using gloves and ventilation mask, if available. If victim is breathing, place him/her in the recovery position, and monitor breathing closely.
   c) Check for signs of circulation such as pulse and coughing, or movement.
   d) If there are no signs of circulation, apply AED immediately. If AED is not immediately available, begin chest compressions and breathing (CPR) until AED arrives.

NOTE: If a rescuer is alone and the victim is a child under eight (8) years old or under 25 kg. (55 lbs.) and has no known cardiac condition, perform one (1) minute of infant/child CPR prior to activating the emergency response system and getting the AED.

5. Turn on the AED.
6. Apply electrode pads (according to diagram on back of electrode pads) to victim's bare chest:
   a) Peel electrode pads, one at a time, from the backing or liner.
   b) Shave or clip chest hair if it is so excessive it prevents a good seal between electrode pads and skin.
   c) Wipe chest clean and dry if victim's chest is dirty or wet.
   d) Press electrode pads firmly to skin.

Use of Automatic External Defibrillators (AED)

DURING SCHOOL HOURS (CONTINUED)

NOTE: If victim is under eight (8) years old or under 25 kg (55 lbs.), remove pre-connected adult defibrillation electrodes, connect Infant/Child Reduced Energy Defibrillation Electrodes to the AED and proceed with steps a, b, c, and d. If pediatric pads are not available, cardiopulmonary resuscitation (CPR) has been tried for a minute, and the child is over one (1) year old, you may use regular adult pads. Do not delay treatment to determine precise age or weight of child. If in doubt, defibrillate with pre-connected defibrillation electrodes.

7. Stand clear of victim while machine evaluates victim's heart rhythm.
8. Refrain from using portable radios or cell phones within four (4) feet of victim while AED is evaluating heart rhythm.

SHOCK ADVISED

1. Clear area, making sure no one is touching the victim.
2. Push SHOCK button when prompted. (If the AED is a fully automatic unit, the shock occurs without rescuer interaction.)
3. Device will analyze the victim's heart rhythm and shock up to three (3) times.
4. After three (3) shocks device will prompt to check for pulse (or for breathing and movement) and, if absent, start CPR.
5. If pulse or signs of circulation such as normal breathing and movement are absent, perform CPR for one (1) minute.
6. Device will count down one (1) minute of CPR and will automatically evaluate victim's heart rhythm when CPR time is over.

NO SHOCK ADVISED

1. Device will prompt to check pulse (or breathing and movement) and if absent, start CPR.
2. If pulse or signs of circulation such as normal breathing and movement are present, perform CPR for one (1) minute.
3. If pulse or signs of circulation are present, check for normal breathing.
4. If victim is not breathing normally, give rescue breathing according to training.
5. AED will automatically evaluate victim's heart rhythm after one (1) minute.
6. If victims regain signs of circulation, such as breathing or movement, place them on their side in the recovery position, and monitor their breathing closely.
7. Continue cycles of heart rhythm evaluations, shocks (if advised) and CPR until professional help arrives.
8. Victim must be transported to hospital.
9. Leave AED attached to victim until EMS arrives, and disconnect AED.
10. Turn over care of the victim to EMS personnel. Once they have arrived, follow the direction of EMS personnel for further actions.

Use of Automatic External Defibrillators (AED)

AFTER SCHOOL HOURS

1. Athletic trainer-covered events:
   a) Determine unresponsiveness
   b) Activate emergency system:
      - At any phone, dial 911.
      - Alert athletic staff of emergency by sending a runner to inform the athletic trainer, athletic director or field/gym manager.
   c) If present, the athletic trainer or designee will retrieve the AED.
   d) If a CPR and/or AED trained individual is available, CPR and AED procedures should be initiated until EMS arrives.
   e) Follow procedure outlined above. See During School Hours section starting with 4a.
2. Other school events (if AED is available)
   a) Determine responsiveness.
   b) Activate emergency system:
      - At any phone, dial 911.
      - Alert the supervising staff member of the emergency.
   c) If CPR/AED trained, the supervising staff will retrieve the AED. CPR and AED procedures should be initiated until EMS arrives
   d) Follow procedure outlined above. See School Hours section starting with 4a.

AFTER USE

1. A copy of AED use information will be sent within 24 hours (weekdays) of the emergency to:
   a) ~~Medical~~ Director of Comprehensive School Health Services
   b) School Nurse~~AED Program Coordinator~~
2. The responder will document the event using the District accident form and will forward a copy of completed form to the Director of Comprehensive School Health Services and School Nurse~~AED Program Coordinator or designee~~ on the next business day.
3. The AED will be wiped clean according to manufacturer guidelines.
4. Electrode pads must be replaced and reconnected to the device (electrode pads and CHARGE-PAK charging unit must be replaced in the LIFEPAK CR Plus AED).
5. Contents of the resuscitation kit must be replaced if used.
6. Critical Event Stress debriefing will be conducted by:
   a) ~~Medical~~ Director of Comprehensive School Health Services
   b) School Nurse~~AED Program Coordinator~~

AED Reporting Form

Submit this form to Superintendent/Director of Comprehensive School Health Services~~designee~~ within forty-eight (48) hours of AED treatment.

EMERGENCY RESPONDER: _____

LOCATION OF AED USE: _____

PATIENT NAME: _____ **DATE OF INCIDENT:** _____

☐ Staff Member ☐ Student ☐ Parent/Visitor

Condition of patient upon arrival (check all that apply)

- ☐ unconscious
- ☐ not breathing
- ☐ no pulse and/or shows signs of circulation such as normal breathing, coughing or movement

NUMBER OF DEFIBRILLATIONS: _____

Please describe the incident from the beginning of the emergency until its conclusion:

_____

_____

_____

_____

_____

Were efforts terminated? ☐ Yes ☐ No If yes, please explain why the efforts were terminated.

_____

_____

_____ _____

Signature of Emergency Responder *Date*