

**MEMORANDUM OF UNDERSTANDING  
BETWEEN THE  
COMMONWEALTH OF MASSACHUSETTS  
AND THE  
COALITION OF PUBLIC SAFETY-UNIT 5  
FOR  
SUCCESSOR AGREEMENTS**

**July 1, 2009 through June 30, 2010**

**July 1, 2010 through June 30, 2013**

The parties agree to the following modifications to the Commonwealth and Coalition of Public Safety Collective Bargaining Agreement for Unit 5, for a successor agreement to the July 1, 2007 through June 30, 2009 Collective Bargaining Agreement:

**Article 6A  
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. Employees who believe they are subject to such behavior should raise their concerns with an appropriate manager or supervisor as soon as possible, but no later than ninety (90) days from the occurrence of the incident(s). In the event the employee(s) concerns are not addressed at the Agency level, whether informally or through the grievance procedure, within a reasonable period of time, the employee or the union may file a grievance at step 3 of the grievance procedure as set forth in Article 23. If an employee, or the union, requests a hearing at step 3, such hearing shall be granted. Grievances filed under this section shall not be subject to the arbitration provisions set forth in Article 23. No employee shall be subject to discrimination for filing a complaint, giving a statement, or otherwise participating in the administration of this program.

**Article 8  
Leave**

The parties agree to establish a labor/management committee to discuss the implementation of biweekly accrual of vacation and sick leave.

**Section 8.1 Sick Leave**

C. (2) When the spouse, child, or parent of either the employee or his/her spouse or a relative living in the immediate household of an employee, is seriously ill, the employee may utilize sick leave credits up to a maximum of **sixty (60) ~~thirty (30)~~ days per calendar year**. When an eligible employee and his/her spouse are both employees of the Commonwealth, they may be jointly granted a total of not more than **thirty (30) ~~sixty (60)~~-days of accrued sick leave as set forth above for parental leave purposes or for the care of a seriously ill parent.**

C. (5) An employee may use up to a maximum of **sixty (60)** ~~thirty (30)~~ days per calendar year for parental leave due to the birth or adoption of a child, to be concluded within twelve (12) months of the date of the birth or adoption. Eligible employees utilizing sick leave under this section shall not be required to submit a medical certification, unless the appointing authority has reason to believe that the birth or adoption claim was not genuine. This leave benefit shall be in addition to the ten (10) days of paid leave set forth in Section 8.7.A.7 below. Where an eligible employee and his/her spouse are both employees of the Commonwealth, they may be jointly granted a total of not more than ~~thirty (30)~~ **sixty (60)** days of accrued sick leave as set forth above for parental leave purposes or for the care of a seriously ill parent.

(6) An employee may use up to a maximum of ten (10) days of accrued sick leave in a calendar year in order to attend to necessary preparations and legal requirements related to the employee's adoption of a child, except that in no event may an employee charge more than a total of **sixty (60)** ~~thirty (30)~~ days of accrued sick leave in a calendar year for adoption related purposes.

### Section 8.3 Bereavement Leave

A. Upon evidence satisfactory to the Appointing Authority of the death of a spouse or child, an employee shall be entitled to a maximum of seven (7) days of leave without loss of pay to be used at the option of the employee within thirty (30) calendar days from the date of said death.

### Section 8.7 Family and Medical Leave

#### B. Medical Leave

1. An Appointing Authority shall grant to a full time or part time employee who has completed his/her probationary period, or if there is no such probationary period, has been employed for at least three (3) consecutive months, an unpaid leave of absence for up to twenty-six (26) weeks to care for a spouse, child or parent who has a serious health condition or for a serious health condition which prevents the employee from being able to perform the function of his/her position. For this leave, under the Family and Medical Leave Act, 29 U.S.C. 26111 et seq., and accompanying regulations, 29 C.F.R. Part 825, the employer may request medical certification after the leave commences if the employer later has reason to question the appropriateness of the leave or its duration. ~~Said certification shall be in accordance with Section 8.1K of this Article.~~

2. Upon the submission of satisfactory medical evidence that demonstrates an existing catastrophic illness, the Appointing Authority shall grant the employee, on a one-time basis, up to an additional twenty-six (26) weeks of non-intermittent FMLA leave.

(re- number remaining Sections accordingly)

3. At least thirty (30) days in advance, the employee shall submit a written notice of his/her intent to take such leave and the dates and expected duration of such leave. The employee shall utilize the medical certification recommended by the Department of Labor (29C.F.R. Section 825.306 (a)), when requesting medical leave or when requested to provide such medical evidence by the Appointing Authority. (See

**Attachment E and F, herein).** If thirty (30) days' notice is not possible, the employee shall give notice as soon as practicable. The employee shall provide, upon request by the Appointing Authority, satisfactory medical evidence. ~~Satisfactory medical evidence is defined under Section 8.1K of this Article.~~ If the Appointing Authority has reason to doubt the validity of the medical evidence, it may obtain a second opinion at its own expense. In the event there is a conflict between the second opinion and the original medical opinion, the Appointing Authority and the employee may resolve the conflict by obtaining the opinion of a third medical provider, who is approved jointly by the Appointing Authority and the employee, at the Appointing Authority's expense.

## **Article 12 Salary Rates**

### **Section 1**

The following shall apply to full-time employees:

- A. Effective June 30, 2011, salary rates shall be increased by one percent (1%).
- B. Effective June 30, 2012, salary rates shall be increased by three percent (3%).
- C. Effective June 30, 2013, salary rates shall be increased by three percent (3%).

## **Article 13A Health and Welfare**

### **Section 2 Funding**

- A. Effective the first pay period in January 2012, the Employer agrees to contribute on behalf of each full-time employee an additional \$.50 per week.

Effective the first pay period in January 2013, the Employer agrees to contribute on behalf of each full time employee an additional \$.50 per week.

## **Wage Re-Opener**

In event that during the term of this Agreement a collective bargaining agreement is submitted by either the Governor or the Secretary for Administration and Finance and said agreement is funded by the Legislature, and in the event that said agreement involves employees in bargaining units 4, 4A, or 5A, in the Commonwealth's Executive Branch whose duties are law enforcement in nature, and in the event that such agreement contains provisions for across the board salary increases which are greater than the across the board salary increases contained in this Agreement, the parties agree to re-open those provisions of this Agreement to further bargaining.

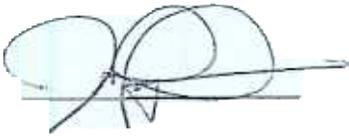
**Article 33  
Duration**

These agreements shall be for a one (1) year period July 1, 2009-June 30, 2010, and a three (3) year period from July 1, 2010-June 30, 2013 and terms contained herein shall become effective on the signing date of the Agreement(s) unless otherwise specified. Should a successor agreement not be executed by June 30, 2013, this Agreement shall remain in full force and effect until a successor agreement is executed or an impasse in negotiations is reached. At the written request of either party, negotiations for a subsequent agreement will be commenced on or before January 1, 2013.

**Other leave**

The Commonwealth agrees that as part of the implementation of this agreement it shall advise departments and agencies that FMLA leaves may be extended or renewed beyond the 26 weeks otherwise provided for in the agreements, at the discretion of the Agency.

**For the Commonwealth:**



**For the Union:**

*Timothy M. Barry* 5-26-11

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Attachment E

**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, 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.

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**

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:**

---

---

---

---

---

---

---

---



**Attachment F**

**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, 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.

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**

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:  
\_\_\_\_\_  
\_\_\_\_\_



---

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:

---

---

---

---

**ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR  
ADDITIONAL ANSWER:**

---

---

---

---

**Signature of Health Care Provider**

---

**Date**