From: [redacted]
To: [redacted]
Cc: [redacted]
Subject: Incident at Guadalupe Division - 1/29/2020
Date: Friday, January 31, 2020 6:33:45 PM
Attachments: image001.png

Hi [redacted] and [redacted],
I received a call from Way, Power and Signal Superintendent, [redacted] on Wednesday, January 29th where he notified me that Supervisor, [redacted] mentioned there had been a verbal altercation during the Way, Power and Signal Annual Maintenance Vacation Sign-up. The incident involved [redacted], and Substation Maintainer, Sam Cassidy, #10391. [redacted] told me he was not provided with any details and asked if I was aware the incident had taken place. I was not prior to speaking with him. Following the call, [redacted] and I met with [redacted] to get her version of events. Per [redacted], she was setting up for the bid right before 6am in the WP&S breakroom when Mr. Cassidy began shouting and pointing at her and, speaking to someone else, said "I want to tell you [redacted] is the most corrupt person at VTA," and that this went on for 2-3 minutes. [redacted] says that she replied with, "That's right. It's me. I'm [redacted]." She also stated that a number of employees were present including ATU representatives [redacted], and ATU Business Agent, [redacted]. The reps stepped in to tell Mr. Cassidy "This was not the time or the place". [redacted] also mentioned discussing the incident with another employee that she didn't want to name who said, "He scares me. If someone was to go postal, it'd be him." My understanding is that the unnamed employee was also present when this took place.
I discussed the incident with [redacted] and she recommended that I reach out to you both to make sure this isn't a complaint better directed to your department.
Please let me know what next steps will be, if any, and if any further information is needed from me.
Thanks,

[redacted]
Santa Clara Valley Transportation Authority
Guadalupe Division
101 W. Younger Ave
San Jose, CA 95110
Phone 408-[redacted]

From: [redacted]
To: [redacted]
Cc:
Subject: Re: Incident at Guadalupe Division - 1/29/2020 - update after speaking with [redacted]
Date: Tuesday, February 4, 2020 5:58:28 PM
Attachments: image001.png

Agreed. Thanks

Get Outlook for iOS

From: [redacted]
Sent: Tuesday, February 4, 2020 4:34:53 PM
To: [redacted]
Cc: [redacted]
Subject: FW: Incident at Guadalupe Division - 1/29/2020 - update after speaking with [redacted]

Hi [redacted],

I spoke to [redacted] about this complaint as we discussed yesterday. She was not familiar with Sam Cassidy and she looked him up and he does not have anything in his disciplinary history that would seem to be of any concern at this point to investigate further. I believe this is something we can refer back to Sam Cassidy's management ([redacted]) to address with him and just to review VTA Policy 410 Standards of Conduct as well as Policy 2120 on Retaliation as anyone can make a complaint or bring up a concern. He can then document he spoke to Sam and provide us that documentation.

[redacted] agreed with this but I wanted to confirm with you first before responding back to this initial email from [redacted]. Please let me know your thoughts. Thanks.

From: [redacted]
Sent: Friday, January 31, 2020 6:34 PM
To: [redacted]; [redacted]
Cc: [redacted]; [redacted]; [redacted]; [redacted]
Subject: Incident at Guadalupe Division - 1/29/2020

Hi [redacted] and [redacted],

I received a call from Way, Power and Signal Superintendent, [redacted] on Wednesday, January 29th where he notified me that Supervisor, [redacted] mentioned there had been a verbal altercation during the Way, Power and Signal Annual Maintenance Vacation Sign-up. The incident involved [redacted], [redacted] and Substation Maintainer, Sam Cassidy, #10391. [redacted] told me he was not provided with any details and asked if I was aware the incident had taken place. I was not prior to speaking with him. Following the call, [redacted] and I met with [redacted] to get her version of events. Per [redacted], she was setting up for the bid right before 6am in the WP&S breakroom when Mr. Cassidy began shouting and pointing at her and, speaking to someone else, said "I want to tell you [redacted] is the most corrupt person at VTA," and that this went on for 2-3 minutes. [redacted] says that she replied with, "That's right. It's me. I'm [redacted]." She also stated that a number of employees were present including ATU representatives [redacted], [redacted], [redacted], [redacted], and ATU Business Agent, [redacted], [redacted]. The reps stepped in to tell Mr. Cassidy "This was not the time or the place". [redacted] also mentioned discussing the incident with another employee that she didn't want to name

who said, “He scares me. If someone was to go postal, it’d be him.” My understanding is that the unnamed employee was also present when this took place.
I discussed the incident with [redacted] and she recommended that I reach out to you both to make sure this isn’t a complaint better directed to your department.
Please let me know what next steps will be, if any, and if any further information is needed from me.
Thanks,

[redacted]
Santa Clara Valley Transportation Authority
Guadalupe Division
101 W. Younger Ave
San Jose, CA 95110
Phone 408-[redacted]

From: [redacted]
To: [redacted]
Cc: [redacted]
Bcc:
Subject: RE: Incident at Guadalupe Division - 1/29/2020
Date: Wednesday, February 5, 2020 9:41:00 AM
Attachments: image001.png

Hi [redacted],

Thank you for the information and for your patience on the follow-up. From the information provided and after speaking with [redacted] and [redacted], it was determined that OCR will not take any further action at this time. OCR recommends that for training and developmental purposes, Sam Cassidy's management:

- Document and speak with Sam Cassidy and review VTA policy #410 (Standards of Conduct), to reinforce appropriate workplace behavior and maintaining satisfactory and harmonious working relationships with other employees;
- Document and speak with Sam Cassidy and review VTA Policy #2120 (Sexual and Other Forms of Harassment of Discrimination), Section 4.6 – Retaliation, to emphasize that anyone at VTA can file a complaint, and retaliation against anyone who complains or participates in a workplace investigation is strictly prohibited.

Thank you.

From: [redacted]
Sent: Friday, January 31, 2020 6:34 PM
To: [redacted]
Cc: [redacted]
Subject: Incident at Guadalupe Division - 1/29/2020

Hi [redacted] and [redacted],

I received a call from Way, Power and Signal Superintendent, [redacted] on Wednesday, January 29th where he notified me that Supervisor, [redacted] mentioned there had been a verbal altercation during the Way, Power and Signal Annual Maintenance Vacation Sign-up. The incident involved [redacted], [redacted] and Substation Maintainer, Sam Cassidy, #10391. [redacted] told me he was not provided with any details and asked if I was aware the incident had taken place. I was not prior to speaking with him. Following the call, [redacted] and I met with [redacted] to get her version of events. Per [redacted], she was setting up for the bid right before 6am in the WP&S breakroom when Mr. Cassidy began shouting and pointing at her and, speaking to someone else, said "I want to tell you [redacted] is the most corrupt person at VTA," and that this went on for 2-3 minutes. [redacted] says that she replied with, "That's right. It's me. I'm [redacted]." She also stated that a number of employees were present including ATU representatives [redacted]

[redacted], [redacted], [redacted], and ATU Business Agent, [redacted], [redacted]. The reps stepped in to tell Mr. Cassidy “This was not the time or the place”. [redacted] also mentioned discussing the incident with another employee that she didn’t want to name who said, “He scares me. If someone was to go postal, it’d be him.” My understanding is that the unnamed employee was also present when this took place.

I discussed the incident with [redacted] and she recommended that I reach out to you both to make sure this isn’t a complaint better directed to your department.

Please let me know what next steps will be, if any, and if any further information is needed from me.

Thanks,

[redacted]

Santa Clara Valley Transportation Authority
Guadalupe Division
101 W. Younger Ave
San Jose, CA 95110
Phone 408-[redacted]

SANTA CLARA
Valley Transportation Authority

Designation Notice
(Family and Medical Leave Act) and California Family Rights Act (CFRA)

Leave covered under the Family and Medical Leave Act & California Family Right Act (FMLA/CFRA) must be designated as FMLA/CFRA protected and the employer must inform the employee of the amount of leave that will be counted against the employee's FMLA/CFRA leave entitlement. In order to determine whether leave is covered under the FMLA/CFRA, the employer may request that the leave be supported by a certification. If the certification is incomplete or insufficient, the employer must state in writing what additional information is necessary to make the certification complete and sufficient.

TO: Samuel Cassidy, #10391
1178 Angmar Court
San Jose, CA 95121

Date: **Friday, August 26, 2016**

We have reviewed your request for leave under the FMLA/CFRA and any supporting documentation that you have provided.
We received your most recent information on **Thursday, August 25, 2016** for leave beginning on Wednesday, August 10, 2016 and decided:

☒ Your FMLA/CFRA leave request is approved. All leave taken for this reason will be designated as FMLA/CFRA Leave. Your health care provider has indicated you will be absent continuously from 8/10/2016 to 9/1/2016.

The FMLA/CFRA required that you notify us as soon as practicable if dates of scheduled leave change or are extended, or were initially unknown. Based on the information you have provided to date, we are providing the following information about the amount of time that will be counted against your leave entitlement:

☒ Provided there is no deviation from your anticipated leave schedule, the following number of hours, days, or weeks will be counted against your leave entitlement**: 17 Days**.

☐ Because the leave you will need will be unscheduled, it is not possible to provide the hours, days, or weeks, that will be counted against your FMLA/CFRA entitlement at this time. You have the right to request this information once in a 30-day period (if leave was taken in the 30-day period).

Please be advised (check if applicable):

☒ All leave taken for this reason will count against your FMLA/CFRA leave entitlement.

☐ We are requiring you to substitute or use paid leave during your FMLA/CFRA leave. Not applicable if receiving third party wages (SDI or II)

☐ You will be required to present a fitness-for-duty certificate to be restored to employment. If such certification is not timely received, your return to work may be delayed until certification is provided. A list of the essential functions of your position ☐ is ☐ is not attached. If attached, the fitness-for-duty certification must address your ability to perform these functions.

☐ Additional information is needed to determine if your FMLA/CFRA leave request can be approved:
☐ The certification you have provided is not complete and sufficient to determine whether the FMLA/CFRA applies to your leave request. You must provide no later than , unless it is not practicable under the particular circumstances despite your diligent good faith efforts, or your leave may be denied.
☐ We are exercising our rights to have you obtain a second or third opinion medical certification at our expense, and we will provide further details at a later time.

☐ Your FMLA/CFRA leave request is NOT approved.
☐ Your FMLA/CFRA does not apply to your leave request.
☐ You have exhausted your FMLA/CFRA leave entitlement in the applicable 12-month period.

c: **Risk Management& Benefits (Benefits only if leave is in excess of 14 days)**

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

OMB Control Number 1235-0003
Expires: 2/28/2015

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: VTA, 3331 N. 1st St, attn: Risk Management San Jose, CA. 95134; fax 408-955-9767 phone 408-321-5692

Employee's job title: _____ Regular work schedule: 40 hour work week

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: Samuel / Cassidy (First) James (Middle) Cassidy (Last) 10391 (Badge/ID#)

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: [redacted]

Type of practice / Medical specialty: General Surgery

Telephone: (408) [redacted] Fax: (408) [redacted]

PART A: MEDICAL FACTS

1. Approximate date condition commenced: 06-14-16 (SURGERY DATE)

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:
08-10-16 (SURGERY DATE)

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:

NO WORK FROM 08-10-16 TO: 09-01-16

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):

DO NOT DISCLOSE PATIENTS DIAGNOSIS. GINA INFORMATION ON PAGE 4.

POST SURGERY REST & CARE

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: 08-10-16

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:
   NO (PART TIME WORK) 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:

   POST - O-P CARE

   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) or _____ month(s)

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

ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER.

OFF WORK 08-10-16 (SURGERY DATE)
TO: 9-1-16

CONTINUED ON NEXT PAGE

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information.

"Genetic information" as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services. and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

MD 08-25-16

Signature of Health Care Provider | Date Signed by Health Care Provider

[redacted] Inc
General Surgery
[redacted]
(408) [redacted]

Date 08-09-16

Re: Patient's Name:

Mr. SAM CASSIDY

To Whom This May Concern:

This is to certify that the patient mentioned above is currently under my care and has been advised that He/She may return to Work/School/ PE on 09-01-16 with the following limitations OFF WORK FROM (08-10-16 SURGERY DATE) TO: 09-01-16

If there are any questions, please contact my office.

Sincerely,

[redacted]

SANTA CLARA
Valley Transportation Authority

Notice of Eligibility and Rights & Responsibilities -Family and Medical Leave Act (FMLA) & California Family Rights Act (CFRA)

In general, to be eligible an employee must have worked for an employer for at least 12 months, have worked at least 1,250 hours in the 12 months preceding the leave, and work at a site with at least 50 employees within 75 miles. Part B provides employees with information regarding their rights and responsibilities for taking FMLA leave, as required by 825.300 (b), (c).

Part A - Notice of Eligibility

To: Samuel Cassidy, #10391
1178 Angmar Court
San Jose, CA 95121

Date: **Thursday, August 11, 2016**

On **Wednesday, August 10, 2016** you informed us that you needed leave beginning on **Wednesday, August 10, 2016** for:

- ☐ The birth of a child, or placement of a child with you for adoption or foster care;
- ☒ Your own serious health condition;
- ☐ Because you are needed to care for ☐ spouse; ☐ child; ☐ parent due to his/her serious health condition.
- ☐ Because of a qualifying exigency arising out of the fact that your ☐ spouse; ☐ son or daughter; ☐ parent is on active duty or call to active duty status in support of a contingency operation as a member of the National Guard or Reserves.
- ☐ Because you are the ☐ spouse; ☐ son or daughter; ☐ parent; ☐ next of kin of a covered service member with a serious injury or illness.

This Notice is to inform you that you:

- ☒ Are eligible for FMLA/CFRA leave (see part B below for Rights & Responsibilities)
- ☐ Are **not** eligible for FMLA/CFRA leave, because (only one reason need be checked, although you may not be eligible for other reasons):
- ☐ You have not met the FMLA's/CFRA's 12-month length of service requirement. As of the first date of requested leave, you will have worked approximately months towards this requirement.
- ☐ You have not met the FMLA's/CFRA's 1,250 hours-worked requirement.

If you have any questions, contact the Risk Management Department at 408-321-5590 or view the FMLA/CFRA poster located in the lunch areas; drivers / mechanic's room; common areas and cafeteria if applicable.

Part B-Rights and Responsibilities for taking FMLA/CFRA Leave

As explained in Part A, you meet the eligibility requirements for taking FMLA/CFRA leave and still have FMLA/CFRA leave available in the applicable 12-month period. However, in order for us to determine whether your absence qualifies as FMLA/CFRA leave, you must return an FMLA Medical Certification form to us by 8/26/16. If sufficient information is not provided in a timely manner, your leave may be denied.

- ☒ Sufficient certification to support your request for FMLA/CFRA leave. A certification form that sets forth the information necessary to support your request is ☒ is not ☐ enclosed. Please have your physician complete and return the enclosed FMLA medical certification no later than 8/26/16.
- ☐ Sufficient documentation to establish the required relationship between you and your family member.
- ☐ Other information needed:
- ☐ No additional information requested;

If your leave does qualify as FMLA leave you will have the following responsibilities while on FMLA/CFRA leave (only checked boxes apply);

☒ Contact VTA Benefits Department at 408-321-5674 to make arrangements to continue to make your share of the premium payments on your health insurance to maintain health benefits while you are on leave. You have a minimum 30-day grace period in which to make premium payments. If payment is not made timely, your group health insurance may be cancelled, provided we notify you in writing at least 15 days before the date that your health coverage will lapse, or, at our option, we may pay your share of the premiums during FMLA/CFRA leave, and recover these payments from you upon your return to work.

☒ You will be required to use your available paid ☒ Sick, ☐ Vacation, and /or ☐ other leave during your FMLA/CFRA absence. This means that you will receive your paid leave and the leave will also be considered protected FMLA/CFRA leave and counted against your FMLA/CFRA leave entitlement.

☐ Due to your status within the company, you are considered a "key employee" as defined in the FMLA/CFRA. as a "key employee," restoration to employment may be denied following FMLA/CFRA leave on the grounds that such restoration will cause substantial and grievous economic injury to us. We ☐ have ☐ have not determined that restoring you to employment at the conclusion of FMLA/CFRA leave will cause substantial and grievous economic harm to us.

☒ While on leave you will be required to furnish us with periodic reports of your status and intent to return to work once every payperiod.

If circumstances of your leave change and you are able to return to work earlier than the date indicated on the reverse side of this form, you will be required to notify VTA at least two workdays prior to the date you intend to report to work.

If your leave does qualify as FMLA/CFRA you will have the following rights while on leave.

- You have a right under the FMLA/CFRA for up to 12 weeks of unpaid leave in a rolling 12-month period, measured backwards from the first date of any FMLA/CFRA leave usage.
- You have a right under the FMLA for up to 26 weeks of unpaid leave in a single 12-month period to care for a covered servicemember with a serious injury or illness. This single 12-month period commenced on_____.
- Your health benefits will be maintained during any period of unpaid leave under the same conditions as if you continued to work.
- You must be reinstated to the same or an equivalent job with the same pay, benefits, and terms and conditions of employment on your return from FMLA/CFRA protected leave. (If your leave extends beyond the 12 weeks entitlement, you do not have return rights.)
- If you do not return to work following FMLA/CFRA leave for a reason other than 1) the continuation, recurrence, or onset of a serious health condition which would entitle you to FMLA/CFRA leave; 2) the continuation, recurrence, or onset of a covered servicemember's serious injury or illness which would entitle you to FMLA/CFRA leave; or 3) other circumstances beyond your control, you may be required to reimburse us for our share of health insurance premiums paid on your behalf during your FMLA leave.
- If we have not informed you above that you must use accrued paid leave while taking your unpaid FMLA/CFRA leave entitlement, you have the right to have ☐ sick, ☐ vacation, and/or ☐ other leave run concurrently with your unpaid leave entitlement. Provided you meet any applicable requirements for taking paid leave, you remain entitled to take unpaid FMLA/CFRA leave.
- For a copy of conditions applicable to sick/vacation/other leave usage please refer to your collective bargaining agreement or VTA's Personnel Policies and Procedures.

Once we obtain the information from you as specified above, we will inform you, within 5 business days, whether your leave will be designated as FMLA/CFRA leave and count towards your FMLA/CFRA leave entitlement.

cc: Risk Management

Santa Clara Valley Transportation Authority

Program ID ZPPRFMLA_NON_OPR - FMLA Leave and Work Hours for Non-Operato
Run ID 08/11/2016 12:51:43 ECP400 VALDEZ_E
Period 08/10/2015 - 08/10/2016

PersNo	Name	Pos. Text	Cost Ctr	Description	Start Date	End Date	Time Type Descriptions	Work Hours	Absence Hours	Hours Available
10391	Cassidy,Samuel	Substation Maintainer	52225	Way, Power & Signal Maintenance	08/10/2015	08/10/2016	SWH - Sum of worked hours	2,068.50	0.00	480.00
*								2,068.50	0.00	

SANTA CLARA
Valley Transportation Authority

This Designation Letter supercedes Letter dated 8/26/16

Designation Notice
(Family and Medical Leave Act) and California Family Rights Act (CFRA)

Leave covered under the Family and Medical Leave Act & California Family Right Act (FMLA/CFRA) must be designated as FMLA/CFRA protected and the employer must inform the employee of the amount of leave that will be counted against the employee's FMLA/CFRA leave entitlement. In order to determine whether leave is covered under the FMLA/CFRA, the employer may request that the leave be supported by a certification. If the certification is incomplete or insufficient, the employer must state in writing what additional information is necessary to make the certification complete and sufficient.

TO: Samuel Cassidy, #10391
1178 Angmar Court
San Jose, CA 95121

Date: **Thursday, September 22, 2016**

We have reviewed your request for leave under the FMLA/CFRA and any supporting documentation that you have provided.
We received your most recent information on **Thursday, September 22, 2016** for leave beginning on Wednesday, August 10, 2016 and decided:

☒ Your FMLA/CFRA leave request is approved. All leave taken for this reason will be designated as FMLA/CFRA Leave. Your health care provider has indicated you will be absent continuously from 8/10/2016 to 9/12/2016.

The FMLA/CFRA required that you notify us as soon as practicable if dates of scheduled leave change or are extended, or were initially unknown. Based on the information you have provided to date, we are providing the following information about the amount of time that will be counted against your leave entitlement:

☒ Provided there is no deviation from your anticipated leave schedule, the following number of hours, days, or weeks will be counted against your leave entitlement: **24 Days**.

☐ Because the leave you will need will be unscheduled, it is not possible to provide the hours, days, or weeks, that will be counted against your FMLA/CFRA entitlement at this time. You have the right to request this information once in a 30-day period (if leave was taken in the 30-day period).

Please be advised (check if applicable):

☒ All leave taken for this reason will count against your FMLA/CFRA leave entitlement.

☐ We are requiring you to substitute or use paid leave during your FMLA/CFRA leave. Not applicable if receiving third party wages (SDI or II)

☐ You will be required to present a fitness-for-duty certificate to be restored to employment. If such certification is not timely received, your return to work may be delayed until certification is provided. A list of the essential functions of your position ☐ is ☐ is not attached. If attached, the fitness-for-duty certification must address your ability to perform these functions.

☐ Additional information is needed to determine if your FMLA/CFRA leave request can be approved:
☐ The certification you have provided is not complete and sufficient to determine whether the FMLA/CFRA applies to your leave request. You must provide no later than , unless it is not practicable under the particular circumstances despite your diligent good faith efforts, or your leave may be denied.
☐ We are exercising our rights to have you obtain a second or third opinion medical certification at our expense, and we will provide further details at a later time.

☐ Your FMLA/CFRA leave request is NOT approved.
☐ Your FMLA/CFRA does not apply to your leave request.
☐ You have exhausted your FMLA/CFRA leave entitlement in the applicable 12-month period.

c: **Risk Management& Benefits (Benefits only if leave is in excess of 14 days)**

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

OMB Control Number: 1235-0003
Expires: 2/28/2015

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: VTA, 3331 N. 1st St, attn: Risk Management San Jose, CA. 95134; fax 408-955-9767 phone 408-321-5592

Employee's job title: _____ Regular work schedule: 40 hour work week

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: Samuel Cassidy James Cassidy 10391
First Middle Last Badge/ID#

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: [redacted]

Type of practice / Medical specialty: General Surgery

Telephone: (408) [redacted] Fax: (408) [redacted]

PART A: MEDICAL FACTS

1. Approximate date condition commenced: 06-14-16 → CONSULTION 06-14-16 (SURGERY DATE) → 8-10-16

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:

08-10-16 (SURGERY DATE)

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:

NO WORK FROM 08-10-16 TO: 09-12-16

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):

DO NOT DISCLOSE PATIENTS DIAGNOSIS. GINA INFORMATION ON PAGE 4.

POST SURGERY REST & CARE

CONTINUED ON NEXT PAGE

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: 08-10-16

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:
   NO (PART TIME WORK) 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:

   POST - O-P CARE

   _____

   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) or _____ month(s)

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

ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER.

OFF WORK 08-10-16 (SURGERY DATE)
TO 09-12-16

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information.

"Genetic information" as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

MD 08-26-16

Signature of Health Care Provider | Date Signed by Health Care Provider

SANTA CLARA
Valley Transportation Authority

RISK MGMT RCVD JUL 17'12

Designation Notice
(Family and Medical Leave Act) and California Family Rights Act (CFRA)

Leave covered under the Family and Medical Leave Act & California Family Right Act (FMLA/CFRA) must be designated as FMLA/CFRA protected and the employer must inform the employee of the amount of leave that will be counted against the employee's FMLA/CFRA leave entitlement. In order to determine whether leave is covered under the FMLA/CFRA, the employer may request that the leave be supported by a certification. If the certification is incomplete or insufficient, the employer must state in writing what additional information is necessary to make the certification complete and sufficient.

TO: **Mr. Samuel Cassidy, #10391**
1178 Angmar Ct.
San Jose, CA 95121

Date: July 17, 2012

We have reviewed your request for leave under the FMLA/CFRA and any supporting documentation that you have provided. We received your most recent information and decided:

☐ Your FMLA/CFRA leave request is approved. All leave taken for this reason will be designated as FMLA/CFRA Leave.

The FMLA/CFRA required that you notify us as soon as practicable if dates of scheduled leave change or are extended, or were initially unknown. Based on the information you have provided to date, we are providing the following information about the amount of time that will be counted against your leave entitlement:

☐ Provided there is no deviation from your anticipated leave schedule, the following number of hours, days, or weeks will be counted against your leave entitlement **(enter hours or days or weeks)** .

☐ Because the leave you will need will be unscheduled, it is not possible to provide the hours, days, or weeks, that will be counted against your FMLA/CFRA entitlement at this time. You have the right to requests this information once in a 30-day period (if leave was taken in the 30-day period).

Please be advised (check if applicable):

☐ You have requested to use paid leave during your FMLA/CFRA leave. Any paid leave taken for this reason will count against your FMLA/CFRA leave entitlement.

☐ We are requiring you to substitute or use paid leave during your FMLA/CFRA leave.

☐ You will be required to present a fitness-for-duty certificate to be restored to employment. If such certification is not timely received, your return to work may be delayed until certification is provided. A list of the essential functions of your position ☐ is ☐ is not attached. If attached, the fitness-for-duty certification must address your ability to perform these functions.

☐ Additional information is needed to determine if your FMLA/CFRA leave request can be approved:

☐ The certification you have provided is not complete and sufficient to determine whether the FMLA/CFRA applies to your leave request. You must provide the following information no later than (provide at least seven calendar days), unless it is not practicable under the particular circumstances despite your diligent good faith efforts, or your leave may be denied. (Specify information needed to make the certification complete and sufficient)

☐ We are exercising our rights to have you obtain a second or third opinion medical certification at our expense, and we will provide further details at a later time.

☒ Your FMLA/CFRA leave request is NOT approved: **You chose not to use FMLA for your absence beginning on June 14, 2012.**
☐ Your FMLA/CFRA does not apply to your leave request.
☐ You have exhausted your FMLA/CFRA leave entitlement in the applicable 12-month period.

c: **Risk Management & Benefits (Benefits only if leave is in excess of 14 days)**

SANTA CLARA
Valley Transportation Authority

Hrs Wrk: 1797.10 Hrs Avail: 480
Hrs Verified: 6/27/12

Notice of Eligibility and Rights & Responsibilities -Family and Medical Leave Act (FMLA) & California Family Rights Act (CFRA)

In general, to be eligible an employee must have worked for an employer for at least 12 months, have worked at least 1,250 hours in the 12 months preceding the leave, and work at a site with at least 50 employees within 75 miles. Part B provides employees with information regarding their rights and responsibilities for taking FMLA leave, as required by 825.300 (b), (c).

Part A - Notice of Eligibility

To: **Mr. Samuel Cassidy, #10391**
1178 Angmar Ct.
San Jose, CA 95121

Date: June 26, 2012

On **June 14, 2012**, you informed us that you needed leave beginning on **June 14, 2012** for:

- ☐ The birth of a child, or placement of a child with you for adoption or foster care;
- ☒ Your own serious health condition;
- ☐ Because you are needed to care for ☐ spouse; ☐ child; ☐parent due to his/her serious health condition.
- ☐ Because of a qualifying exigency arising out of the fact that your ☐ spouse; ☐ son or daughter; ☐parent is on active duty or call to active duty status in support of a contingency operation as a member of the National Guard or Reserves.
- ☐ Because you are the ☐ spouse; ☐ son or daughter; ☐ parent; ☐ next of kin of a covered service member with a serious injury or illness.

This Notice is to inform you that you:

- ☒ Are eligible for FMLA/CFRA leave (see part B below for Rights & Responsibilities)
- ☐ Are **not** eligible for FMLA/CFRA leave, because (only one reason need be checked, although you may not be eligible for other reasons):
- ☐ You have not met the FMLA's/CFRA's 12-month length of service requirement. As of the first date of requested leave, you will have worked approximately months towards this requirement.
- ☐ You have not met the FMLA's/CFRA's 1,250 hours-worked requirement.

If you have any questions, contact the Risk Management Department at 408-321-5590 or view the FMLA/CFRA poster located in the lunch areas; drivers / mechanic's room; common areas and cafeteria if applicable.

Part B-Rights and Responsibilities for taking FMLA/CFRA Leave

As explained in Part A, you meet the eligibility requirements for taking FMLA/CFRA leave and still have FMLA/CFRA leave available in the applicable 12-month period. However, in order for us to determine whether your absence qualifies as FMLA/CFRA leave, you must return the following information to us by **July 12, 2012** (If a certification is requested, employers must allow at least 15 calendar days from receipt of this notice; additional time may be required in some circumstances.) If sufficient information is not provided in a timely manner, your leave may be denied.

- ☒ Sufficient certification to support your request for FMLA/CFRA leave. A certification form that sets forth the information necessary to support your request is ☒ is not☐ enclosed.
- ☐ Sufficient documentation to establish the required relationship between you and your family member.
- ☐ Other information needed:
- ☐ No additional information requested;

If your leave does qualify as FMLA leave you will have the following responsibilities while on FMLA/CFRA leave (only checked boxes apply);

☒ Contact VTA Benefits Department at 408-321-5674 to make arrangements to continue to make your share of the premium payments on you health insurance to maintain health benefits while you are on leave. You have a minimum 30-day grace period in which to make premium payments. If payment is not made timely, your group health insurance may be cancelled, provided we notify you in writing at least 15 days before the date that your health coverage will lapse, or, at our option, we may pay your share of the premiums during FMLA/CFRA leave, and recover these payments from you upon your return to work.

☒ You will be required to use your available paid _☒ Sick, ☐ Vacation, and /or ☐ other leave during your FMLA/CFRA absence. This means that you will receive your paid leave and the leave will also be considered protected FMLA/CFRA leave and counted against your FMLA/CFRA leave entitlement.

☐ Due to your status within the company, you are considered a "key employee" as defined in the FMLA/CFRA. as a "key employee," restoration to employment may be denied following FMLA/CFRA leave on the grounds that such restoration will cause substantial and grievous economic injury to us. We ☐ have ☐ have not determined that restoring you to employment at the conclusion of FMLA/CFRA leave will cause substantial and grievous economic harm to us.

☒ While on leave you will be required to furnish us with periodic reports of your status and intent to return to work once every payperiod.

If circumstances of your leave change and you are able to return to work earlier than the date indicated on the reverse side of this form, you will be required to notify VTA at least two workdays prior to the date you intend to report to work.

If your leave does qualify as FMLA/CFRA you will have the following rights while on leave.

- You have a right under the FMLA/CFRA for up to 12 weeks of unpaid leave in a rolling 12-month period, measured backwards from the first date of any FMLA/CFRA leave usage.
- You have a right under the FMLA for up to 26 weeks of unpaid leave in a single 12-month period to care for a covered servicemember with a serious injury or illness. This single 12-month period commenced on_____.
- Your health benefits will be maintained during any period of unpaid leave under the same conditions as if you continued to work.
- You must be reinstated to the same or an equivalent job with the same pay, benefits, and terms and conditions of employment on your return from FMLA/CFRA protected leave. (If your leave extends beyond the 12 weeks entitlement, you do not have return rights.)
- If you do not return to work following FMLA/CFRA leave for a reason other than 1) the continuation, recurrence, or onset of a serious health condition which would entitle you to FMLA/CFRA leave; 2) the continuation, recurrence, or onset of a covered servicemember's serious injury or illness which would entitle you to FMLA/CFRA leave; or 3) other circumstances beyond your control, you may be required to reimburse us for our share of health insurance premiums paid on your behalf during your FMLA leave.
- If we have not informed you above that you must use accrued paid leave while taking your unpaid FMLA/CFRA leave entitlement, you have the right to have ☒ sick, ☐ vacation, and/or ☐ other leave run concurrently with your unpaid leave entitlement. Provided you meet any applicable requirements for taking paid leave, you remain entitled to take unpaid FMLA/CFRA leave.
- For a copy of conditions applicable to sick/vacation/other leave usage please refer to your collective bargaining agreement or VTA's Personnel Policies and Procedures.

Once we obtain the information from you as specified above, we will inform you, within 5 business days, whether your leave will be designated as FMLA/CFRA leave and count towards your FMLA/CFRA leave entitlement.

[redacted]

From: [redacted]
Sent: Friday, May 28, 2021 6:41 AM
To: [redacted]
Subject: FW: FMLA

Here is his response to my email

From: samuel cassidy <sammyc29@att.net>
Sent: Thursday, July 16, 2020 11:59 AM
To: [redacted]
Cc: [redacted] >
Subject: Re: FMLA

i flat out refuse to do that.....if you fully read the documents and ask my supervisor when my first day off of work for this condition.....which was tuesday july 14th 2020. i gave her plently of heads up notice starting by phone conversation on friday july 10th 2020 off my upcoming off time.
[redacted] you should be able to deduce the date you need to know from the included paperwork or cal[redacted] or call my doctor.
i am not making a trip down to see the doctor for this minor detail. i consider this harassment
sam cassidy
On Thursday, July 16, 2020, 11 03 08 AM PDT,[redacted] wrote

Samuel,

Your medical certification is incomplete; the doctor failed to indicate the beginning date for the period of incapacity. Please take the form back to your doctor and have him write a beginning date for the period of incapacity in question 5. Any revisions made to this document must be initialed by the doctor. You have 7 days to give this back to VTA. This is due by July 22.

[redacted]

From: samuel cassidy <sammyc29@att.net>
Sent: Thursday, July 16, 2020 10 48 AM
To: [redacted]
Cc: [redacted]
Subject: Re FMLA

hi[redacted].....attached are my FMLA and doctors report.

regards

sam cassidy

On Tuesday, July 14, 2020, 05 48 04 AM PDT,[redacted] > wrote

Hi Sam,

Please, send your FMLA forms to[redacted] and myself.[redacted] is the contact person in River Oaks.

Thanks,

[redacted]

LR Power Supervisor

Way Power and Signals

101 W younger Ave Bldg B

San Jose ca 95110

Phone **408**[redacted]

Mobile[redacted]

[redacted]

From: [redacted]
To: [redacted]
Subject: FW: FMLA
Date: Wednesday, June 2, 2021 1:46:44 PM
Attachments: image002.png
image003.jpg

From: [redacted]
Sent: Friday, May 28, 2021 6:42 AM
To: [redacted]
Subject: FW: FMLA

Here is a chain of emails after he refused to take the form to his doctor I agreed to contact the doctor and obtained the missing information

From: [redacted]
Sent: Thursday, July 16, 2020 1:22 PM
To: 'samuel cassidy' <sammyc29@att.net>; [redacted]
Cc: [redacted]
Subject: RE: FMLA

Sam,

I can fax the document back to him, not a problem I just ask that you call him and let him know that this is coming his way and to please return it back to me when the change is made

Sometimes the doctors need the patient s permission to communicate with the employer

I will be faxing this form to your doctor before 3 00 p m today

[redacted]
Human Resources Analyst
408[redacted]

From: samuel cassidy <sammyc29@att.net>
Sent: Thursday, July 16, 2020 1:17 PM
To: [redacted]
Cc: [redacted]
Subject: Re: FMLA

1) he doesnt have a form to revise
2) if he has to completely refill out a blank form just for this purpose sounds rediculous
3) how about if you fax my doctor just the page i alteady sent you and ask him to input the beginning date, then he can fax it back to you so its less of a hassle for all involved parties
regards
sam cassidy
On Thursday, July 16, 2020, 01:03:45 PM PDT, [redacted] > wrote:

Samuel,

your supervisor cannot contact your doctor. It is against FMLA regulations.

You don't need to physically take the document to him. You can get this done by email or fax. For FMLA purposes, we need a complete medical certification. The doctor is required to tell us when the condition started. I understand your supervisor knows when you first booked off for this absence, however, the medical certification is a tool that is in place to confirm that the condition in fact started on the day you did not report to work. The question on the form clearly states "*estimate the beginning and ending dates for the period of incapacity*" – the beginning date is missing. Nowhere in this document did the doctor mentioned when the period of incapacity started.

Again, you do not have to physically take this form back to your doctor, you can call him and explain to him what your employer is asking for. He can send you a revised form via email or he can fax it directly back to me. This is required under the FMLA regulations and FMLA policy.

My fax number is 408[redacted].

Regards,

[redacted]
Human Resources Analyst

408[redacted]

From: samuel cassidy <sammyc29@att.net>
Sent: Thursday, July 16, 2020 11:59 AM
To: [redacted]
Cc: [redacted]
Subject: Re: FMLA

i flat out refuse to do that.....if you fully read the documents and ask my supervisor when my first day off of work for this condition.....which was tuesday july 14th 2020. i gave her plently of heads up notice starting by phone conversation on friday july 10th 2020 off my upcoming off time.

[redacted] you should be able to deduce the date you need to know from the included paperwork or cal [redacted] or call my doctor.

i am not making a trip down to see the doctor for this minor detail. i consider this harassment

sam cassidy

On Thursday, July 16, 2020, 11:03:08 AM PDT, [redacted] > wrote:

Samuel,

Your medical certification is incomplete; the doctor failed to indicate the beginning date for the period of incapacity. Please take the form back to your doctor and have him write a beginning date for the period of incapacity in question 5. Any revisions made to this document must be initialed by the doctor. You have 7 days to give this back to VTA. This is due by July 22.

[redacted]
Human Resources Analyst

408[redacted]

From: samuel cassidy <sammyc29@att.net>
Sent: Thursday, July 16, 2020 10:48 AM
To: [redacted]
Cc: [redacted]
Subject: Re: FMLA

h[redacted] and[redacted] .....attached are my FMLA and doctors report.

regards

sam cassidy

On Tuesday, July 14, 2020, 05:48:04 AM PDT,[redacted] wrote:

Hi Sam,

Please, send your FMLA forms to[redacted] and myself,[redacted] is the contact person in River Oaks.

Thanks,

[redacted]

LR Power Supervisor

Way Power and Signals

101 W younger Ave Bldg B

San Jose ca 95110

Phone **408**[redacted]

Mobile[redacted]

From: [redacted]
To: [redacted]
Subject: FW: FMLA
Date: Wednesday, June 2, 2021 1:44:29 PM
Attachments: image001.png
20200716103616257-1.pdf

From: [redacted]
Sent: Friday, May 28, 2021 6:39 AM
To: [redacted]
Subject: FW: FMLA

Good morning,
Here is an email that I received from Mr. Cassidy on 7/16/2020.
I will be in the office at 7:30 and will send you anything else I can find on this person.
[redacted]

From: samuel cassidy <sammyc29@att.net>
Sent: Thursday, July 16, 2020 10:48 AM
To: [redacted]
Cc: [redacted]>; [redacted]>
Subject: Re: FMLA

hi [redacted], [redacted] and [redacted].....attached are my FMLA and doctors report.
regards
sam cassidy
On Tuesday, July 14, 2020, 05:48:04 AM PDT, [redacted]> wrote:

Hi Sam,

Please, send your FMLA forms to [redacted] and myself. [redacted] is the contact person in River Oaks.

Thanks,

[redacted]

LR Power Supervisor

Way Power and Signals

101 W. younger Ave Bldg. B

San Jose ca 95110

Phone **408-**[redacted]

Mobile [redacted]

Sam Cassidy

Left foot problem:

02/18/20 primary care appointment/office visit

02/19/20 foot x Ray primary care office visit.

02/26/20 [redacted] office visit

03/11/20 [redacted] office visit

03/25/20 MRI

04/09/20 [redacted] office visit

05/07/20 [redacted] office visit

05/27/20 [redacted] office visit

06/04/20 [redacted] office visit

07/09/20 [redacted] office visit

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: VTA Benefits - 3331 N. First Street San Jose, CA 95134; fax 408.955.9728

Employee's job title: Bus Op 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: Samuel James Cassidy
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: [redacted]

Type of practice / Medical specialty: Foot & Ankle Surgery

Telephone: (406) [redacted] Fax: (406) [redacted]

PART A: MEDICAL FACTS

1. Approximate date condition commenced: 1-2020

Probable duration of condition: 6 30 2020

Mark below as applicable:

Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility?
X No ___Yes. If so, dates of admission:

Date(s) you treated the patient for condition:
2/26/20 thru present

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

Was medication, other than over-the-counter medication, prescribed? X No ___Yes.

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

2. Is the medical condition pregnancy? X 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 X Yes.

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

All Employee

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): Has Inflammation 9 Months Plate L7 and MRI Need to see foot + Ankle

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you do not provide any genetic information when responding to this request for medical information. "Genetic Information" as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assisted reproductive services.

CONTINUED ON NEXT PAGE

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 X Yes.

   If so, estimate the beginning and ending dates for the period of incapacity: 8/24/20

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? X 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 X Yes.

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

   Maybe

   _____

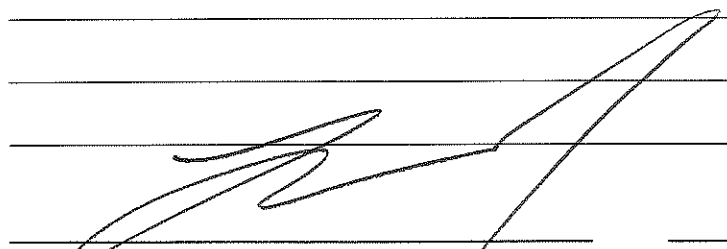
   Based upon the patient's medical history and your knowledge of the medical condition, estimate the frequency of flare-ups and the duration of related incapacity that the patient may have over the next 6 months (e.g., 1 episode every 3 months lasting 1-2 days):

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

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

ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER.

Have to see Outcome to Answer the Question after 4 wk of rest



7-16-20

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.**

PROGRESS NOTE

PATIENT'S NAME: Samuel Cassidy
ACCOUNT #: 111632
DOB: 08/29/1963
DOS: 07/09/2020

I have not seen this patient for a few weeks, and he stated that after he is off or rest his foot for a few days, it feels much better but once he returns to work, the symptoms reoccur. I have given him three Kenalog injections in the past from which he has had minimal relief.

At this point after discussing with the patient, it was felt that he should be off of work for three weeks and then return on the fourth week and see if this will help heal the situation. I will see him again in four weeks.

[redacted]

Santa Clara Valley Transportation Authority

Notice of Eligibility and Rights & Responsibilities -Family and Medical Leave Act (FMLA) & California Family Rights Act (CFRA)

In general, to be eligible an employee must have worked for an employer for at least 12 months, have worked at least 1,250 hours in the 12 months preceding the leave, and work at a site with at least 50 employees within 75 miles. Part B provides employees with information regarding their rights and responsibilities for taking FMLA leave, as required by 825.300 (b), (c).

Part A - Notice of Eligibility

To: Name Sam Cassidy
Address: 1178 Angmar Court San Jose, CA 95121

Date: 7/14/20

You requested FMLA protection for your absence beginning on 7/14/20 for:

- ☐ The birth of a child, or placement of a child with you for adoption or foster care;
- ☒ Your own serious health condition;
- ☐ Because you are needed to care for ☐ spouse; ☐ child; ☐ a parent due to his/her serious health condition.
- ☐ Because of a qualifying exigency arising out of the fact that your ☐ spouse; ☐ son or daughter; ☐parent is on active duty or call to active duty status in support of a contingency operation as a member of the National Guard or Reserves.
- ☐ Because you are the ☐ spouse; ☐ son or daughter; ☐ parent; ☐ next of kin of a covered service member with a serious injury or illness.
- ☐ **This absence is a work related absence and may be designated as FMLA.**

This Notice is to inform you that you:

- ☒ Are eligible for FMLA/CFRA leave (see part B below for Rights & Responsibilities)
- ☐ Are **not** eligible for FMLA/CFRA leave, because (only one reason need be checked, although you may not be eligible for other reasons):
- ☐ You have not met the FMLA's/CFRA's 12-month length of service requirement. As of the first date of requested leave, you will have worked approximately months towards this requirement.
- ☐ You have not met the FMLA's/CFRA's 1,250 hours-worked requirement.

If you have any questions, contact the Benefits Department at 408-952-8919 or view the FMLA/CFRA poster located in the lunch areas; drivers / mechanic's room; common areas and cafeteria if applicable.

Part B-Rights and Responsibilities for taking FMLA/CFRA Leave

As explained in Part A, you meet the eligibility requirements for taking FMLA/CFRA leave and still have FMLA/CFRA leave available in the applicable 12-month period. However, in order for us to determine whether your medical condition qualifies as FMLA/CFRA leave, you must return the following information to us **by 7/29/20.**
If sufficient information is not provided in a timely manner, your leave may be denied. IF IT IS NOT PRACTICABLE FOR YOU TO COMPLY WITH THE ABOVE DATE FOR SUBMISSION OF YOUR MEDICAL CERTIFICATION YOU MUST SUBMIT TO YOUR SUPERINTENDENT/SUPERVISOR A WRITTEN STATEMENT OUTLINING THE CIRCUMSTANCES THAT CAUSE YOU TO BE UNABLE TO COMPLY WITH THIS FMLA REGULATION. YOUR FAILURE TO PROVIDE THIS INFORMATION AS SOON AS PRACTICABLE MAY RESULT IN A DENIAL OF YOUR REQUEST FOR FMLA PROTECTION.

- ☒ Sufficient certification is needed to support your request for FMLA/CFRA leave. A certification form that sets forth the information necessary to support your request is ☒ is not ☐enclosed;
- ☐ Sufficient documentation to establish the required relationship between you and your family member;
- ☐ Other information needed:
- ☐ No additional information requested;

If your leave does qualify as FMLA leave you will have the following responsibilities while on FMLA/CFRA leave (only checked boxes apply);

☒ Contact VTA Benefits Department at 408-952-8919 to make arrangements to continue to make your share of the premium payments on your health insurance to maintain health benefits while you are on leave. You have a minimum 30-day grace period in which to make premium payments. If payment is not made timely, your group health insurance may be cancelled, provided we notify you in writing at least 15 days before the date that your health coverage will lapse, or, at our option, we may pay your share of the premiums during FMLA/CFRA leave, and recover these payments from you upon your return to work.

☒ You will be required to use your available paid __☒__ Sick, __☐__ Vacation, and /or ____ other leave during your FMLA/CFRA absence. This means that you will receive your paid leave and the leave will also be considered protected FMLA/CFRA leave and counted against your FMLA/CFRA leave entitlement.

☐ Due to your status within the company, you are considered a "key employee" as defined in the FMLA/CFRA. as a "key employee," restoration to employment may be denied following FMLA/CFRA leave on the grounds that such restoration will cause substantial and grievous economic injury to us. We ☐ have ☐ have not determined that restoring you to employment at the conclusion of FMLA/CFRA leave will cause substantial and grievous economic harm to us.

☒ While on leave you will be required to furnish us with periodic reports of your status and intent to return to work once every payperiod.

If circumstances of your leave change and you are able to return to work earlier than the date indicated on the reverse side of this form, you will be required to notify VTA at least two workdays prior to the date you intend to report to work.

If your leave does qualify as FMLA/CFRA you will have the following rights while on leave.

- You have a right under the FMLA/CFRA for up to 12 weeks of unpaid leave in a rolling 12-month period, measured backwards from the first date of any FMLA/CFRA leave usage.
- You have a right under the FMLA for up to 26 weeks of unpaid leave in a single 12-month period to care for a covered servicemember with a serious injury or illness. This single 12-month period commenced on 7/14/20.
- Your health benefits will be maintained during any period of unpaid leave under the same conditions as if you continued to work.
- You must be reinstated to the same or an equivalent job with the same pay, benefits, and terms and conditions of employment on your return from FMLA/CFRA protected leave. (If your leave extends beyond the 12 weeks entitlement, you do not have return rights.)
- If you do not return to work following FMLA/CFRA leave for a reason other than 1) the continuation, recurrence, or onset of a serious health condition which would entitle you to FMLA/CFRA leave; 2) the continuation, recurrence, or onset of a covered servicemember's serious injury or illness which would entitle you to FMLA/CFRA leave; or 3) other circumstances beyond your control, you may be required to reimburse us for our share of health insurance premiums paid on your behalf during your FMLA leave.
- If we have not informed you above that you must use accrued paid leave while taking your unpaid FMLA/CFRA leave entitlement, you have the right to have ☒ sick, ☒ vacation, and/or ☒ other leave run concurrently with your unpaid leave entitlement. Provided you meet any applicable requirements for taking paid leave, you remain entitled to take unpaid FMLA/CFRA leave.
- For a copy of conditions applicable to sick/vacation/other leave usage please refer to your collective bargaining agreement or VTA's Personnel Policies and Procedures.

Once we obtain the information from you as specified above, we will inform you, within 5 business days, whether your leave will be designated as FMLA/CFRA leave and count towards your FMLA/CFRA leave entitlement.

From: [redacted]
To: [redacted]
Subject: FW: FMLA
Date: Friday, May 28, 2021 6:43:42 AM
Attachments: image001.png
image002.png
Cassidy, Samuel.pdf

Sam s doctor responded to my query and a complete certification was received on 7/21 He received FMLA protection for his absence

---

From: [redacted]
Sent: Tuesday, July 21, 2020 8:32 AM
To: [redacted]
Cc: [redacted]
Subject: RE: FMLA

[redacted] :

Attached is the revised medical certification Please issue a designation letter and code Sam s absence accordingly If this employee is applying for SDI benefits, please make sure his time is integrated, unless, he requests in writing that his sick accruals not be integrated

Thanks

[redacted]
Human Resources Analyst
408[redacted]

From: [redacted]
Sent: Thursday, July 16, 2020 1:22 PM
To: 'samuel cassidy' <sammyc29@att net>; [redacted]
Cc: [redacted]
Subject: RE: FMLA

Sam,

I can fax the document back to him, not a problem I just ask that you call him and let him know that this is coming his way and to please return it back to me when the change is made Sometimes the doctors need the patient s permission to communicate with the employer

I will be faxing this form to your doctor before 3 00 p m today

[redacted]
Human Resources Analyst
408[redacted]

From: samuel cassidy <sammyc29@att net>
Sent: Thursday, July 16, 2020 1:17 PM
To: [redacted]
Cc: [redacted]
Subject: Re: FMLA

1) he doesnt have a form to revise
2) if he has to completely refill out a blank form just for this purpose sounds rediculous
3) how about if you fax my doctor just the page i alteady sent you and ask him to input the beginning date, then he can fax it back to you so its less of a hassle for all involved parties

regards
sam cassidy

On Thursday, July 16, 2020, 01:03:45 PM PDT, [redacted] > wrote:

Samuel,

your supervisor cannot contact your doctor. It is against FMLA regulations.

You don't need to physically take the document to him. You can get this done by email or fax. For FMLA purposes, we need a complete medical certification. The doctor is required to tell us when the condition started. I understand your supervisor knows when you first booked off for this absence, however, the medical certification is a tool that is in place to confirm that the condition in fact started on the day you did not report to work. The question on the form clearly states "*estimate the beginning and ending dates for the period of incapacity*" – the beginning date is missing. Nowhere in this document did the doctor mentioned when the period of incapacity started.

Again, you do not have to physically take this form back to your doctor, you can call him and explain to him what your employer is asking for. He can send you a revised form via email or he can fax it directly back to me. This is required under the FMLA regulations and FMLA policy.

My fax number is [redacted].

Regards,

[redacted]
Human Resources Analyst
408[redacted]

From: samuel cassidy <sammyc29@att.net>
Sent: Thursday, July 16, 2020 11:59 AM
To: [redacted]
Cc: [redacted]
Subject: Re: FMLA

i flat out refuse to do that.....if you fully read the documents and ask my supervisor when my first day off of work for this condition.....which was tuesday july 14th 2020. i gave her plently of heads up notice starting by phone conversation on friday july 10th 2020 off my upcoming off time.

[redacted] you should be able to deduce the date you need to know from the included paperwork or cal [redacted] or call my doctor.

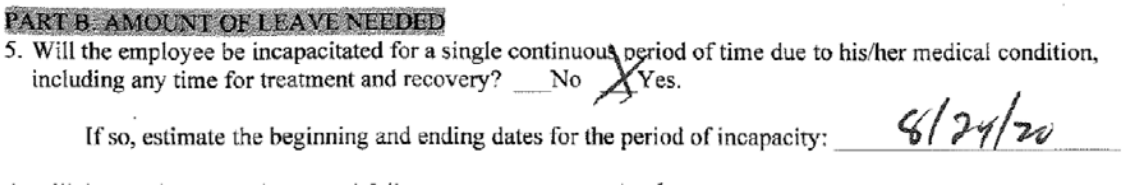
i am not making a trip down to see the doctor for this minor detail. i consider this harassment

sam cassidy

On Thursday, July 16, 2020, 11:03:08 AM PDT, [redacted] wrote:

Samuel,

Your medical certification is incomplete; the doctor failed to indicate the beginning date for the period of incapacity. Please take the form back to your doctor and have him write a beginning date for the period of incapacity in question 5. Any revisions made to this document must be initialed by the doctor. You have 7 days to give this back to VTA. This is due by July 22.



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 X Yes.

If so, estimate the beginning and ending dates for the period of incapacity: 6/24/20

[redacted]
Human Resources Analyst
408[redacted]

From: samuel cassidy <sammyc29@att.net>
Sent: Thursday, July 16, 2020 10:48 AM
To: [redacted]
Cc: [redacted]
Subject: Re: FMLA

hi [redacted], [redacted] and [redacted].....attached are my FMLA and doctors report.

regards

sam cassidy

On Tuesday, July 14, 2020, 05:48:04 AM PDT, [redacted] wrote:

Hi Sam,

Please, send your FMLA forms to [redacted] and myself. [redacted] is the contact person in River Oaks.

Thanks,

[redacted]
LR Power Supervisor
Way Power and Signals
101 W younger Ave Bldg B
San Jose ca 95110
Phone 408[redacted]
Mobile [redacted]

Santa Clara Valley Transportation Authority

Solutions that move you

** INBOUND NOTIFICATION : FAX RECEIVED SUCCESSFULLY **

TIME RECEIVED	REMOTE CSID	DURATION	PAGES	STATUS
July 16, 2020 at 2:50:08 PM PDT	[redacted]	279	6	Received

2020-07-16 16:48 CDT -

[redacted]

[redacted]

[redacted]

Fax

To: [redacted]

Fax: [redacted] **Date:** 7/16/20

Phone: **Pages:** 6 (including cover sheet)

Re: Documents requested/received

☐ [redacted] ☒ [redacted] ☐ [redacted]

Comments:

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: VTA Benefits - 3331 N. First Street San Jose, CA 95134 fax 408 955 9728

Employee's job title: Bus Op 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: Samuel James Cassidy
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: [redacted]

Type of practice / Medical specialty: Family Medicine Surgery

Telephone: (408) [redacted] Fax: (408) [redacted]

2020-07-16 16:48 CDT - [redacted]

PART A: MEDICAL FACTS

1. Approximate date condition commenced: 1-2020

Probable duration of condition: 8 30 2020

Mark below as applicable:

Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility?
X No ___ Yes. If so, dates of admission:

Date(s) you treated the patient for condition:
2/26/20 thru present

Will the patient need to have treatment visits at least twice per year due to the condition? ___ No X Yes.

Was medication, other than over-the-counter medication, prescribed? X No ___ Yes.

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

2. Is the medical condition pregnancy? X 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 X Yes.

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

VTA Employee

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): Has Inflammation of Multiple [illegible]

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you do not provide any genetic information when responding to this request for medical information. "Genetic Information" as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assisted reproductive services.

 CONTINUED ON NEXT PAGE

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 X Yes.

   If so, estimate the beginning and ending dates for the period of incapacity: 7/14/20 - 8/24/20

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? X 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 X Yes.

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

   Maybe

   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):

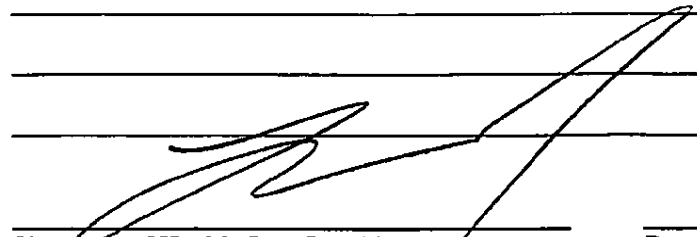
Frequency: ___ times per ___ week(s) ___ month(s)

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

ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER.

Have to see Dr come to answer the question after 4 wk of rest

 CONTINUED ON NEXT PAGE



7-16-20

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.**

From: [redacted]
To: [redacted]
Subject: FW: FMLA
Date: Friday, May 28, 2021 6:40:37 AM
Attachments: image001.png
image002.png
20200716103616257-1.pdf
Importance: High

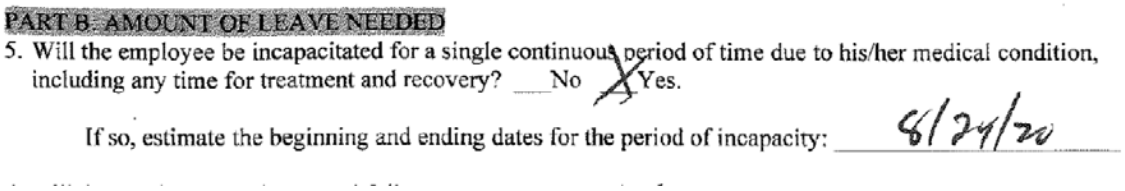
The medical certification he provided for FMLA leave was insufficient when I told him he needed to take the certification back to his doctor he refused to do it His response is below

---

From: [redacted]
Sent: Thursday, July 16, 2020 11:03 AM
To: 'samuel cassidy' <sammyc29@att net>; [redacted]
Cc: [redacted]
Subject: RE: FMLA
Importance: High

Samuel,

Your medical certification is incomplete; the doctor failed to indicate the beginning date for the period of incapacity Please take the form back to your doctor and have him write a beginning date for the period of incapacity in question 5 Any revisions made to this document must be initialed by the doctor You have 7 days to give this back to VTA This is due by July 22



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 X Yes.

If so, estimate the beginning and ending dates for the period of incapacity: 6/24/20

[redacted]
Human Resources Analyst
408 [redacted]

From: samuel cassidy <sammyc29@att net>
Sent: Thursday, July 16, 2020 10:48 AM
To: [redacted]
Cc: [redacted]
Subject: Re: FMLA

hi [redacted] and [redacted] .....attached are my FMLA and doctors report.

regards
sam cassidy

On Tuesday, July 14, 2020, 05 48 04 AM PDT, [redacted] wrote

Hi Sam,

Please, send your FMLA forms to [redacted] and myself. [redacted] is the contact person in River Oaks.

Thanks,

[redacted]
LR Power Supervisor
Way Power and Signals
101 W younger Ave Bldg B
San Jose ca 95110
Phone **408** [redacted]
Mobile [redacted]

Santa Clara Valley Transportation Authority
Solutions that move you

Conserve paper. Think before you print.

Sam Cassidy

Left foot problem:

02/18/20 primary care appointment/office visit

02/19/20 foot x Ray primary care office visit.

02/26/20 [redacted] office visit

03/11/20 [redacted] office visit

03/25/20 MRI

04/09/20 [redacted] office visit

05/07/20 [redacted] office visit

05/27/20 [redacted] office visit

06/04/20 [redacted] office visit

07/09/20 [redacted] office visit

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: VTA Benefits - 3331 N. First Street San Jose, CA 95134; fax 408.955.9728

Employee's job title: Bus Op 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: Samuel James Cassidy
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: [redacted]

Type of practice / Medical specialty: Foot & Ankle Surgery

Telephone: (406) [redacted] Fax: (406) [redacted]

PART A: MEDICAL FACTS

1. Approximate date condition commenced: 1-2020

Probable duration of condition: 6 30 2020

Mark below as applicable:

Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility?
X No ___Yes. If so, dates of admission:

Date(s) you treated the patient for condition:
2/26/20 thru present

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

Was medication, other than over-the-counter medication, prescribed? X No ___Yes.

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

2. Is the medical condition pregnancy? X 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 X Yes.

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

All Employee

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): Has Inflammation 9 Months Plate L7 and MRI Need to see foot + Ankle

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you do not provide any genetic information when responding to this request for medical information. "Genetic Information" as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assisted reproductive services.

CONTINUED ON NEXT PAGE

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 X Yes.

   If so, estimate the beginning and ending dates for the period of incapacity: 8/24/20

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? X 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 X Yes.

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

   Maybe

   _____

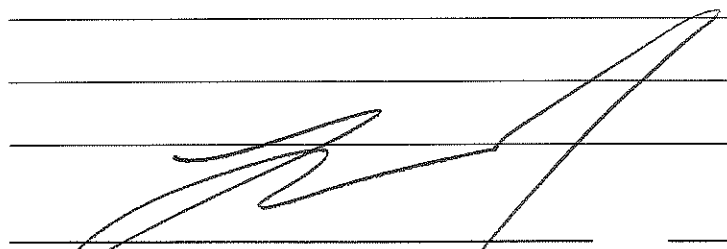
   Based upon the patient's medical history and your knowledge of the medical condition, estimate the frequency of flare-ups and the duration of related incapacity that the patient may have over the next 6 months (e.g., 1 episode every 3 months lasting 1-2 days):

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

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

ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER.

Have to see Outcome to Answer the Question after 4 wk of rest



7-16-20

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.**

PROGRESS NOTE

PATIENT'S NAME: Samuel Cassidy
ACCOUNT #: 111632
DOB: 08/29/1963
DOS: 07/09/2020

I have not seen this patient for a few weeks, and he stated that after he is off or rest his foot for a few days, it feels much better but once he returns to work, the symptoms reoccur. I have given him three Kenalog injections in the past from which he has had minimal relief.

At this point after discussing with the patient, it was felt that he should be off of work for three weeks and then return on the fourth week and see if this will help heal the situation. I will see him again in four weeks.

[redacted]

Santa Clara Valley Transportation Authority

Notice of Eligibility and Rights & Responsibilities -Family and Medical Leave Act (FMLA) & California Family Rights Act (CFRA)

In general, to be eligible an employee must have worked for an employer for at least 12 months, have worked at least 1,250 hours in the 12 months preceding the leave, and work at a site with at least 50 employees within 75 miles. Part B provides employees with information regarding their rights and responsibilities for taking FMLA leave, as required by 825.300 (b), (c).

Part A - Notice of Eligibility

To: Name Sam Cassidy
Address: 1178 Angmar Court San Jose, CA 95121

Date: 7/14/20

You requested FMLA protection for your absence beginning on 7/14/20 for:

- ☐ The birth of a child, or placement of a child with you for adoption or foster care;
- ☒ Your own serious health condition;
- ☐ Because you are needed to care for ☐ spouse; ☐ child; ☐ a parent due to his/her serious health condition.
- ☐ Because of a qualifying exigency arising out of the fact that your ☐ spouse; ☐ son or daughter; ☐parent is on active duty or call to active duty status in support of a contingency operation as a member of the National Guard or Reserves.
- ☐ Because you are the ☐ spouse; ☐ son or daughter; ☐ parent; ☐ next of kin of a covered service member with a serious injury or illness.
- ☐ **This absence is a work related absence and may be designated as FMLA.**

This Notice is to inform you that you:

- ☒ Are eligible for FMLA/CFRA leave (see part B below for Rights & Responsibilities)
- ☐ Are **not** eligible for FMLA/CFRA leave, because (only one reason need be checked, although you may not be eligible for other reasons):
- ☐ You have not met the FMLA's/CFRA's 12-month length of service requirement. As of the first date of requested leave, you will have worked approximately months towards this requirement.
- ☐ You have not met the FMLA's/CFRA's 1,250 hours-worked requirement.

If you have any questions, contact the Benefits Department at 408-952-8919 or view the FMLA/CFRA poster located in the lunch areas; drivers / mechanic's room; common areas and cafeteria if applicable.

Part B-Rights and Responsibilities for taking FMLA/CFRA Leave

As explained in Part A, you meet the eligibility requirements for taking FMLA/CFRA leave and still have FMLA/CFRA leave available in the applicable 12-month period. However, in order for us to determine whether your medical condition qualifies as FMLA/CFRA leave, you must return the following information to us **by 7/29/20.**
If sufficient information is not provided in a timely manner, your leave may be denied. IF IT IS NOT PRACTICABLE FOR YOU TO COMPLY WITH THE ABOVE DATE FOR SUBMISSION OF YOUR MEDICAL CERTIFICATION YOU MUST SUBMIT TO YOUR SUPERINTENDENT/SUPERVISOR A WRITTEN STATEMENT OUTLINING THE CIRCUMSTANCES THAT CAUSE YOU TO BE UNABLE TO COMPLY WITH THIS FMLA REGULATION. YOUR FAILURE TO PROVIDE THIS INFORMATION AS SOON AS PRACTICABLE MAY RESULT IN A DENIAL OF YOUR REQUEST FOR FMLA PROTECTION.

- ☒ Sufficient certification is needed to support your request for FMLA/CFRA leave. A certification form that sets forth the information necessary to support your request is ☒ is not ☐enclosed;
- ☐ Sufficient documentation to establish the required relationship between you and your family member;
- ☐ Other information needed:
- ☐ No additional information requested;

If your leave does qualify as FMLA leave you will have the following responsibilities while on FMLA/CFRA leave (only checked boxes apply);

☒ Contact VTA Benefits Department at 408-952-8919 to make arrangements to continue to make your share of the premium payments on your health insurance to maintain health benefits while you are on leave. You have a minimum 30-day grace period in which to make premium payments. If payment is not made timely, your group health insurance may be cancelled, provided we notify you in writing at least 15 days before the date that your health coverage will lapse, or, at our option, we may pay your share of the premiums during FMLA/CFRA leave, and recover these payments from you upon your return to work.

☒ You will be required to use your available paid __☒__ Sick, __☐__ Vacation, and /or ____ other leave during your FMLA/CFRA absence. This means that you will receive your paid leave and the leave will also be considered protected FMLA/CFRA leave and counted against your FMLA/CFRA leave entitlement.

☐ Due to your status within the company, you are considered a "key employee" as defined in the FMLA/CFRA. as a "key employee," restoration to employment may be denied following FMLA/CFRA leave on the grounds that such restoration will cause substantial and grievous economic injury to us. We ☐ have ☐ have not determined that restoring you to employment at the conclusion of FMLA/CFRA leave will cause substantial and grievous economic harm to us.

☒ While on leave you will be required to furnish us with periodic reports of your status and intent to return to work once every payperiod.

If circumstances of your leave change and you are able to return to work earlier than the date indicated on the reverse side of this form, you will be required to notify VTA at least two workdays prior to the date you intend to report to work.

If your leave does qualify as FMLA/CFRA you will have the following rights while on leave.

- You have a right under the FMLA/CFRA for up to 12 weeks of unpaid leave in a rolling 12-month period, measured backwards from the first date of any FMLA/CFRA leave usage.
- You have a right under the FMLA for up to 26 weeks of unpaid leave in a single 12-month period to care for a covered servicemember with a serious injury or illness. This single 12-month period commenced on 7/14/20.
- Your health benefits will be maintained during any period of unpaid leave under the same conditions as if you continued to work.
- You must be reinstated to the same or an equivalent job with the same pay, benefits, and terms and conditions of employment on your return from FMLA/CFRA protected leave. (If your leave extends beyond the 12 weeks entitlement, you do not have return rights.)
- If you do not return to work following FMLA/CFRA leave for a reason other than 1) the continuation, recurrence, or onset of a serious health condition which would entitle you to FMLA/CFRA leave; 2) the continuation, recurrence, or onset of a covered servicemember's serious injury or illness which would entitle you to FMLA/CFRA leave; or 3) other circumstances beyond your control, you may be required to reimburse us for our share of health insurance premiums paid on your behalf during your FMLA leave.
- If we have not informed you above that you must use accrued paid leave while taking your unpaid FMLA/CFRA leave entitlement, you have the right to have ☒ sick, ☒ vacation, and/or ☒ other leave run concurrently with your unpaid leave entitlement. Provided you meet any applicable requirements for taking paid leave, you remain entitled to take unpaid FMLA/CFRA leave.
- For a copy of conditions applicable to sick/vacation/other leave usage please refer to your collective bargaining agreement or VTA's Personnel Policies and Procedures.

Once we obtain the information from you as specified above, we will inform you, within 5 business days, whether your leave will be designated as FMLA/CFRA leave and count towards your FMLA/CFRA leave entitlement.

From: [redacted]
To: [redacted]
Subject: FW: FMLA
Date: Friday, May 28, 2021 6:39:30 AM
Attachments: image001.png
20200716103616257-1.pdf

Good morning,

Here is an email that I received from Mr. Cassidy on 7/16/2020.

I will be in the office at 7:30 and will send you anything else I can find on this person.

[redacted]

From: samuel cassidy <sammyc29@att.net>
Sent: Thursday, July 16, 2020 10:48 AM
To: [redacted]
Cc: [redacted]
Subject: Re: FMLA

h[redacted], [redacted] and [redacted].....attached are my FMLA and doctors report.

regards
sam cassidy

On Tuesday, July 14, 2020, 05:48:04 AM PDT, [redacted] wrote:

Hi Sam,

Please, send your FMLA forms to [redacted] and myself. [redacted] is the contact person in River Oaks.

Thanks,

[redacted]

LR Power Supervisor

Way Power and Signals

101 W. younger Ave Bldg. B

San Jose ca 95110

Phone **408-**[redacted]

Mobile [redacted]

Santa Clara Valley Transportation Authority

Solutions that move you

Conserve paper. Think before you print.

Sam Cassidy

Left foot problem:

02/18/20 primary care appointment/office visit

02/19/20 foot x Ray primary care office visit.

02/26/20 [redacted] office visit

03/11/20 [redacted] office visit

03/25/20 MRI

04/09/20 [redacted] office visit

05/07/20 [redacted] office visit

05/27/20 [redacted] office visit

06/04/20 [redacted] office visit

07/09/20 [redacted] office visit

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: VTA Benefits - 3331 N. First Street San Jose, CA 95134; fax 408.955.9728

Employee's job title: Bus Op 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: Samuel James Cassidy
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: [redacted]

Type of practice / Medical specialty: Foot & Ankle Surgery

Telephone: (406) [redacted] Fax: (406) [redacted]

PART A: MEDICAL FACTS

1. Approximate date condition commenced: 1-2020

Probable duration of condition: 6 30 2020

Mark below as applicable:

Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility?
X No ___Yes. If so, dates of admission:

Date(s) you treated the patient for condition:
2/26/20 thru present

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

Was medication, other than over-the-counter medication, prescribed? X No ___Yes.

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

2. Is the medical condition pregnancy? X 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 X Yes.

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

All Employee

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): Has Inflammation 9 Months Plate L7 and MRI Need to see foot + Ankle

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you do not provide any genetic information when responding to this request for medical information. "Genetic Information" as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assisted reproductive services.

CONTINUED ON NEXT PAGE

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 X Yes.

   If so, estimate the beginning and ending dates for the period of incapacity: 8/24/20

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? X 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 X Yes.

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

   Maybe

   _____

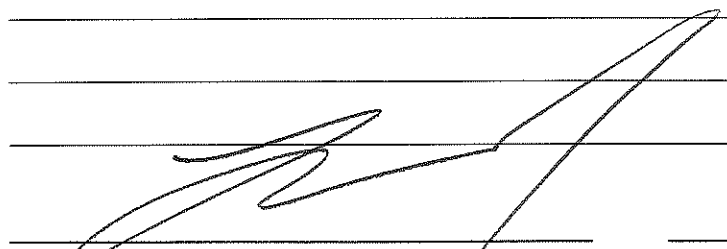
   Based upon the patient's medical history and your knowledge of the medical condition, estimate the frequency of flare-ups and the duration of related incapacity that the patient may have over the next 6 months (e.g., 1 episode every 3 months lasting 1-2 days):

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

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

ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER.

Have to see Outcome to Answer the Question after 4 wk of rest



7-16-20

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.**

PROGRESS NOTE

PATIENT'S NAME: Samuel Cassidy
ACCOUNT #: 111632
DOB: 08/29/1963
DOS: 07/09/2020

I have not seen this patient for a few weeks, and he stated that after he is off or rest his foot for a few days, it feels much better but once he returns to work, the symptoms reoccur. I have given him three Kenalog injections in the past from which he has had minimal relief.

At this point after discussing with the patient, it was felt that he should be off of work for three weeks and then return on the fourth week and see if this will help heal the situation. I will see him again in four weeks.

Santa Clara Valley Transportation Authority

Notice of Eligibility and Rights & Responsibilities -Family and Medical Leave Act (FMLA) & California Family Rights Act (CFRA)

In general, to be eligible an employee must have worked for an employer for at least 12 months, have worked at least 1,250 hours in the 12 months preceding the leave, and work at a site with at least 50 employees within 75 miles. Part B provides employees with information regarding their rights and responsibilities for taking FMLA leave, as required by 825.300 (b), (c).

Part A - Notice of Eligibility

To: Name Sam Cassidy
Address: 1178 Angmar Court San Jose, CA 95121

Date: 7/14/20

You requested FMLA protection for your absence beginning on 7/14/20 for:

- ☐ The birth of a child, or placement of a child with you for adoption or foster care;
- ☒ Your own serious health condition;
- ☐ Because you are needed to care for ☐ spouse; ☐ child; ☐ a parent due to his/her serious health condition.
- ☐ Because of a qualifying exigency arising out of the fact that your ☐ spouse; ☐ son or daughter; ☐parent is on active duty or call to active duty status in support of a contingency operation as a member of the National Guard or Reserves.
- ☐ Because you are the ☐ spouse; ☐ son or daughter; ☐ parent; ☐ next of kin of a covered service member with a serious injury or illness.
- ☐ **This absence is a work related absence and may be designated as FMLA.**

This Notice is to inform you that you:

- ☒ Are eligible for FMLA/CFRA leave (see part B below for Rights & Responsibilities)
- ☐ Are **not** eligible for FMLA/CFRA leave, because (only one reason need be checked, although you may not be eligible for other reasons):
- ☐ You have not met the FMLA's/CFRA's 12-month length of service requirement. As of the first date of requested leave, you will have worked approximately months towards this requirement.
- ☐ You have not met the FMLA's/CFRA's 1,250 hours-worked requirement.

If you have any questions, contact the Benefits Department at 408-952-8919 or view the FMLA/CFRA poster located in the lunch areas; drivers / mechanic's room; common areas and cafeteria if applicable.

Part B-Rights and Responsibilities for taking FMLA/CFRA Leave

As explained in Part A, you meet the eligibility requirements for taking FMLA/CFRA leave and still have FMLA/CFRA leave available in the applicable 12-month period. However, in order for us to determine whether your medical condition qualifies as FMLA/CFRA leave, you must return the following information to us **by 7/29/20.**
If sufficient information is not provided in a timely manner, your leave may be denied. IF IT IS NOT PRACTICABLE FOR YOU TO COMPLY WITH THE ABOVE DATE FOR SUBMISSION OF YOUR MEDICAL CERTIFICATION YOU MUST SUBMIT TO YOUR SUPERINTENDENT/SUPERVISOR A WRITTEN STATEMENT OUTLINING THE CIRCUMSTANCES THAT CAUSE YOU TO BE UNABLE TO COMPLY WITH THIS FMLA REGULATION. YOUR FAILURE TO PROVIDE THIS INFORMATION AS SOON AS PRACTICABLE MAY RESULT IN A DENIAL OF YOUR REQUEST FOR FMLA PROTECTION.

- ☒ Sufficient certification is needed to support your request for FMLA/CFRA leave. A certification form that sets forth the information necessary to support your request is ☒ is not ☐enclosed;
- ☐ Sufficient documentation to establish the required relationship between you and your family member;
- ☐ Other information needed:
- ☐ No additional information requested;

If your leave does qualify as FMLA leave you will have the following responsibilities while on FMLA/CFRA leave (only checked boxes apply);

☒ Contact VTA Benefits Department at 408-952-8919 to make arrangements to continue to make your share of the premium payments on your health insurance to maintain health benefits while you are on leave. You have a minimum 30-day grace period in which to make premium payments. If payment is not made timely, your group health insurance may be cancelled, provided we notify you in writing at least 15 days before the date that your health coverage will lapse, or, at our option, we may pay your share of the premiums during FMLA/CFRA leave, and recover these payments from you upon your return to work.

☒ You will be required to use your available paid __☒__ Sick, __☐__ Vacation, and /or ____ other leave during your FMLA/CFRA absence. This means that you will receive your paid leave and the leave will also be considered protected FMLA/CFRA leave and counted against your FMLA/CFRA leave entitlement.

☐ Due to your status within the company, you are considered a "key employee" as defined in the FMLA/CFRA. as a "key employee," restoration to employment may be denied following FMLA/CFRA leave on the grounds that such restoration will cause substantial and grievous economic injury to us. We ☐ have ☐ have not determined that restoring you to employment at the conclusion of FMLA/CFRA leave will cause substantial and grievous economic harm to us.

☒ While on leave you will be required to furnish us with periodic reports of your status and intent to return to work once every payperiod.

If circumstances of your leave change and you are able to return to work earlier than the date indicated on the reverse side of this form, you will be required to notify VTA at least two workdays prior to the date you intend to report to work.

If your leave does qualify as FMLA/CFRA you will have the following rights while on leave.

- You have a right under the FMLA/CFRA for up to 12 weeks of unpaid leave in a rolling 12-month period, measured backwards from the first date of any FMLA/CFRA leave usage.
- You have a right under the FMLA for up to 26 weeks of unpaid leave in a single 12-month period to care for a covered servicemember with a serious injury or illness. This single 12-month period commenced on 7/14/20.
- Your health benefits will be maintained during any period of unpaid leave under the same conditions as if you continued to work.
- You must be reinstated to the same or an equivalent job with the same pay, benefits, and terms and conditions of employment on your return from FMLA/CFRA protected leave. (If your leave extends beyond the 12 weeks entitlement, you do not have return rights.)
- If you do not return to work following FMLA/CFRA leave for a reason other than 1) the continuation, recurrence, or onset of a serious health condition which would entitle you to FMLA/CFRA leave; 2) the continuation, recurrence, or onset of a covered servicemember's serious injury or illness which would entitle you to FMLA/CFRA leave; or 3) other circumstances beyond your control, you may be required to reimburse us for our share of health insurance premiums paid on your behalf during your FMLA leave.
- If we have not informed you above that you must use accrued paid leave while taking your unpaid FMLA/CFRA leave entitlement, you have the right to have ☒ sick, ☒ vacation, and/or ☒ other leave run concurrently with your unpaid leave entitlement. Provided you meet any applicable requirements for taking paid leave, you remain entitled to take unpaid FMLA/CFRA leave.
- For a copy of conditions applicable to sick/vacation/other leave usage please refer to your collective bargaining agreement or VTA's Personnel Policies and Procedures.

Once we obtain the information from you as specified above, we will inform you, within 5 business days, whether your leave will be designated as FMLA/CFRA leave and count towards your FMLA/CFRA leave entitlement.

From: [redacted]
To: [redacted]
Subject: FW: Please Fax for Me: Sam Cassidy Medical
Date: Friday, May 28, 2021 6:44:16 AM
Attachments: Cover letter Sam Cassidy.docx
Samuel Cassidy certification.pdf
Importance: High

These are the documents that were faxed to Mr. Cassidy's doctor.

From: [redacted]
Sent: Thursday, July 16, 2020 1:39 PM
To: [redacted]
Subject: FW: Please Fax for Me: Sam Cassidy Medical
Importance: High

[redacted],

I need to ask you for a big favor. Can you please fax the attached documents to Dr. [redacted] [redacted] before 3:00 p.m. today?
Fax number: (408) [redacted].

When you are done, go ahead and keep these documents in your work area (protected from any one's view) and return to me next week when I am in the office.

Thank you.

[redacted]
Human Resources Analyst
408 [redacted]

Conserve paper. Think before you print.

July 16, 2020

To: Dr. [redacted]

From: [redacted], VTA Human Resources

Subject: Samuel Cassidy Medical Certification – Information Needed

Dr. [redacted], your patient Samuel Cassidy provided us with the attached medical certification dated July 16, 2020. The document is incomplete because you did not indicate when the period of incapacity began. This information is needed on question number 5.

I ask that you please write in the certification the date when the single period of incapacity began, initial the change, and fax the revised document to my attention. My fax number is 408[redacted].

If you have any questions, you may reach me at 408 [redacted].

Thank you,

[redacted]

Human Resources Analyst

VTA Benefits

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: VTA Benefits - 3331 N. First Street San Jose, CA 95134; fax 408.955.9728

Employee's job title: Bus Op 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: Samuel James Cassidy
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: [redacted]

Type of practice / Medical specialty: Foot & Ankle Surgery

Telephone: (408) [redacted] Fax: (408) [redacted]

PART A: MEDICAL FACTS

1. Approximate date condition commenced: 1-2020

Probable duration of condition: 6 30 2020

Mark below as applicable:

Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility?
X No ___Yes. If so, dates of admission:

Date(s) you treated the patient for condition:
2/26/20 thru present

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

Was medication, other than over-the-counter medication, prescribed? X No ___Yes.

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

2. Is the medical condition pregnancy? X 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 X Yes.

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

All Employee

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): Has Inflammation 9 Months Plate L7 and MRI Need to see foot + Ankle

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you do not provide any genetic information when responding to this request for medical information. "Genetic Information" as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assisted reproductive services.

CONTINUED ON NEXT PAGE

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 X Yes.

   If so, estimate the beginning and ending dates for the period of incapacity: 8/24/20

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? X 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 X Yes.

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

   Maybe

   _____

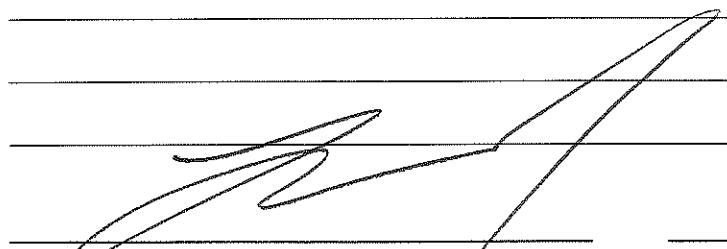
   Based upon the patient's medical history and your knowledge of the medical condition, estimate the frequency of flare-ups and the duration of related incapacity that the patient may have over the next 6 months (e.g., 1 episode every 3 months lasting 1-2 days):

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

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

ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER.

Have to see Outcome to Answer the Question after 4 wk of rest



7-16-20

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.**

PROGRESS NOTE

PATIENT'S NAME: Samuel Cassidy
ACCOUNT #: 111632
DOB: 08/29/1963
DOS: 07/09/2020

I have not seen this patient for a few weeks, and he stated that after he is off or rest his foot for a few days, it feels much better but once he returns to work, the symptoms reoccur. I have given him three Kenalog injections in the past from which he has had minimal relief.

At this point after discussing with the patient, it was felt that he should be off of work for three weeks and then return on the fourth week and see if this will help heal the situation. I will see him again in four weeks.

[redacted]

[redacted]

From: [redacted]
Sent: Wednesday, February 10, 2021, 11:08 AM
To: [redacted]
Cc: [redacted]
Subject: FW: Samuel Cassidy #747 - Unprofessional radio communication and refusing an instruction from OCC

Hi [redacted],

I have counselled Sam for his behavior in presence of his Union Rep. [redacted]. I apologize for the inconvenience, this has caused to OCC.

Regards,
[redacted]

From: [redacted]
Sent: Wednesday, February 10, 2021 11:05 AM
To: [redacted]
Cc: Cassidy, Samuel <Samuel.Cassidy@vta.org>
Subject: RE: Samuel Cassidy #747 - Unprofessional radio communication and refusing an instruction from OCC

Hi [redacted],

As per our meeting yesterday, Sam was counseled on his code of conduct. Just want to remind and reiterate on our agreement/conclusion, this behavior by Sam must not be repeated again. Any similar violation will lead to disciplinary action.

Regards,
[redacted]

From: [redacted]
Sent: Tuesday, February 9, 2021 9:08 AM
To: [redacted]
Cc: [redacted]
Subject: Samuel Cassidy #747 - Unprofessional radio communication and refusing an instruction from OCC

Good morning [redacted],

Per our conversation, at 0833 today, 2/9/21, Samuel Cassidy #747 notified OCC that he was at Sub 4 and the Rail Controller copied his traffic. He allegedly did not here her response and pressed his EA. When asked if he had an emergency, he responded that he pressed his EA because his radio traffic was not answered. I became aware of the situation and requested a 10-21, which he refused and communicated unprofessionally and unnecessarily on the radio. The WAV file is attached. Please make sure this situation is addressed in a timely manner.

Thank you,

[redacted]

Santa Clara Valley Transportation Authority
101 W. Younger Avenue, Building A
San Jose, CA 95110-1719
[redacted]

Santa Clara Valley Transportation Authority
Solutions that move you

[redacted]

From: [redacted]
Sent: Tuesday, February 9, 2021, 9:07 AM
To: [redacted]
Cc: [redacted]
Subject: Samuel Cassidy #747 - Unprofessional radio communication and refusing an instruction from OCC

Good morning [redacted],

Per our conversation, at 0833 today, 2/9/21, Samuel Cassidy #747 notified OCC that he was at Sub 4 and the Rail Controller copied his traffic. He allegedly did not here her response and pressed his EA. When asked if he had an emergency, he responded that he pressed his EA because his radio traffic was not answered. I became aware of the situation and requested a 10-21, which he refused and communicated unprofessionally and unnecessarily on the radio. The WAV file is attached. Please make sure this situation is addressed in a timely manner.

Thank you,

[redacted]

Santa Clara Valley Transportation Authority
101 W. Younger Avenue, Building A
San Jose, CA 95110-1719
[redacted]

Santa Clara Valley Transportation Authority
Solutions that move you

[redacted]

From: [redacted]
Sent: Saturday, November 28, 2020 8:05 AM
To: [redacted]
Cc: [redacted]
Subject: Samuel Cassidy #747 book off

Good morning,

Samuel Cassidy #747 called OCC today, 11/28/20, at 0606 on LR Channel 2 and stated that he attempted to badge in at 0558 and he was unable to due to the Sign-in Terminal (SIT) not working. He stated, “So I’m scheduled to work today, but I’m going to go home. If VTA can’t have a system for an employee to badge in, then I’m just going to go home. This is my normal work day. You can put me down as unexcused leave.” The Rail Controller requested that he give OCC a land line and he stated, “Negative, I’m just going home right now.” He was then advised to make sure he also notifies his supervisor.

This is considered unnecessary radio traffic and should not be transmitted on an open line for multiple employees to hear. Please remind Mr. Cassidy that a conversation such as this should be handled via telephone.

Thank you,

[redacted]

Santa Clara Valley Transportation Authority
101 W. Younger Avenue, Building A
San Jose, CA 95110-1719
[redacted]

Santa Clara Valley Transportation Authority
Solutions that move you

From: [redacted]
To: [redacted]
Cc: [redacted]
Subject: Courtney Cassidy Memo
Date: Thursday, July 18, 2019 12:49:15 PM
Attachments: image001.png
Courtney Cassidy Memo.docx

[redacted] asked that I put something together to memorialize the meeting with [redacted], concerning Samuel Cassidy, insubordination/removal from service. I do not have much experience drafting any sort of agreements with the Union and am hoping you could possibly put this in the proper format if that is what is needed. Please let me know if this is acceptable or provide some examples of agreements and I could try and get it in the proper format.

[redacted]
Santa Clara Valley Transportation Authority
101 West Younger Ave
San Jose, CA 95110
[redacted]

Santa Clara Valley Transportation Authority

MEMORANDUM

Writer's Direct Telephone (408) 546-7659

TO: [redacted]

CC: Sam Cassidy, [redacted]

FROM: [redacted], [redacted]

DATE: July 18, 2019

SUBJECT: Samuel Cassidy, 10391-Removal from Service

On July 17, 2019 we met to discuss the Insubordination and Removal from Service of Samuel Cassidy, also in attendance was [redacted]. In order to get Samuel back to work it was agreed in order to issue a radio, that you, as his Union Representative would sign the "Portable Radio Equipment Sign Out-Individual", noting that he refused to sign. You stated you would work with Labor Relations on a long-term solution for this issue. Additionally, it was agreed that Sam would be coded for excused leave without pay for his time removed from service and no discipline would be pursued for this incident.

From: [redacted]
To: Cassidy, Samuel
Cc: [redacted]
Subject: CPR training
Date: Friday, October 30, 2020 10:40:41 AM
Attachments: image001.png
California Code of Regulations, Title 8, Section 2940.10. Medical Services and First Aid - Additional Requirements for Power Generation, Transmission and Distribution..html

---

Hi Sam,
You are required to take CPR training by CAL OSHA as highlighted below. Please, response with accommodations you feel are needed to take this course.
EXCEPTION to subsection (c)(1)(B): Where the existing number of employees is insufficient to meet this requirement (at a remote substation, for example), all employees at the work location shall be trained.
Thanks,

[redacted]
Way Power and Signals
101 W. younger Ave Bldg. B
San Jose ca 95110
[redacted]

Skip to Main Content

Subchapter 5. Electrical Safety Orders
Group 2. High-Voltage Electrical Safety Orders
Article 36. Work Procedures and Operating Procedures

Return to index
New query

---

§2940.10. Medical Services and First Aid - Additional Requirements for Power Generation, Transmission and Distribution.

(a) Application. This section applies to:
(1) Power generation, transmission, and distribution installations, including, but not limited to, related equipment for the purpose of communication or metering, which are accessible only to qualified employees.
The types of installations covered by this section include the generation, transmission, and distribution installations of electric utilities, as well as equivalent installations of industrial establishments. Supplementary electric generating equipment that is used to supply a workplace for emergency, standby, or similar purposes only is covered under other parts of these Orders.
(2) Other installations at an electric power generating station, as follows:
(A) Fuel and ash handling and processing installations, such as coal conveyors,
(B) Water and steam installations, such as penstocks, pipelines, and tanks, providing a source of energy for electric generators, and
(C) Chlorine and hydrogen systems.
(3) Test sites where electrical testing involving temporary measurements associated with electric power generation, transmission, and distribution is performed in laboratories, in the field, in substations, and on lines, as opposed to metering, relaying, and routine line work.
(4) Work on, or directly associated with, the installations covered in subsections (a)(1) through (a)(3) and
(5) Line-clearance tree-trimming operations.
NOTE: See Article 38, for additional requirements for line-clearance tree-trimming operations.
(b) This Section 2940.10 does not apply to:
(1) Construction work.
(2) Electrical installations other than power generation, transmission and distribution.
(3) Electric utilization systems.
(4) Premises wiring.
(c) The employer shall provide medical services and first aid as required in General Industry Safety Orders, Section 3400. In addition to the requirements of Section 3400, the following requirements also apply:
(1) Cardiopulmonary resuscitation and first aid training. When employees are performing work on or associated with exposed lines or equipment energized at 50 volts or more, persons trained in first aid including cardiopulmonary resuscitation (CPR) shall be available as follows:
(A) For field work involving two or more employees at a work location, at least two trained persons shall be available.

EXCEPTION: to subsection (c)(1)(A): For line clearance operations performed by line-clearance trainees under the direct supervision and instruction of a qualified line clearance tree trimmer, only one trained person need be available if all new employees are trained in first aid, including CPR, within 3 months of their hiring dates.
(B) For fixed work locations such as generating stations, the number of trained persons available shall be sufficient to ensure that each employee exposed to electric shock can be reached within 4 minutes by a trained person.
EXCEPTION to subsection (c)(1)(B): Where the existing number of employees is insufficient to meet this requirement (at a remote substation, for example), all employees at the work location shall be trained.
(2) First aid supplies. First aid supplies required by Section 3400(c) shall be placed in weatherproof containers if the supplies could be exposed to the weather.
(3) First aid kits. Each first aid kit shall be maintained, shall be readily available for use, and shall be inspected frequently enough to ensure that expended items are replaced but at least once per year.
Note: Authority cited: Section 142.3, Labor Code. Reference: Section 142.3, Labor Code.
HISTORY
1. New section filed 10-27-2011; operative 10-27-2011. Submitted to OAL for printing only pursuant to Labor Code section 142.3 (Register 2011, No. 43).
2. Amendment of section heading and section filed 9-5-2012; operative 10-5-2012 (Register 2012, No. 36).
3. Redesignation of former subsections (a)(2)a.-c. as subsections (a)(2)(A)-(C) and former subsection (c)(1)a.-b. as subsections (c)(1)(A)-(B) and amendment of Exceptions to subsections (c)(1)(A) and (c)(1)(B) filed 2-27-2018; operative 4-1-2018 (Register 2018, No. 9).

Go Back to Article 36 Table of Contents

From:
To: [redacted]
Subject: FW: Pics Sam Cassidy
Date: Tuesday, July 16, 2019 4:56:36 PM
Attachments: IMG_0021.JPG
Untitled attachment 00004.txt
IMG_0023.JPG
Untitled attachment 00007.txt

The first memo was issued by [redacted] summarizing the events.

The 2nd document is what the employee is refusing to sign.

-----Original Message-----
From: [redacted]
Sent: Tuesday, July 16, 2019 10:10 AM
To: [redacted]
Subject: FW: Pics Sam Cassidy

Hi [redacted]
Here is what I got from WPS this am.
To be honest I am not sure why Sam refused to sign, some folks are just that way but I think a simple solution would be to have the Supervisor write "Refused to sign" then initial it.
This should be done with a Shop Steward as a witness and in front of the camera would be an additional protection for VTA.
Your thoughts?
[redacted]

ATU Local 265
[redacted]
1590 La Pradera Dr.
Campbell, CA 95008
[redacted]
Fax # (408) 874-0907

-----Original Message-----
From: [redacted]
Sent: Tuesday, July 16, 2019 9:50 AM
To [redacted]
Subject: Pics Sam Cassidy

Santa Clara Valley Transportation Authority

MEMORANDUM

Writer's Direct Telephone [redacted]

TO: Sam Cassidy, [redacted]

FROM: [redacted] Way Power and Signals

DATE: July 16, 2019

SUBJECT: Removal from Service

This morning I met with Sam Cassidy also in attendance were [redacted] and [redacted] concerning his refusal to sign the "Portable Radio Equipment Sign Out-Individual" in which a radio cannot be issued without signing. I advised him that failing to sign could lead to charges of insubordination and he would be removed from service as a radio is a critical piece of safety equipment required for him to perform his duties. He continued to refuse to sign after multiple request.

Sam Cassidy is removed from service this morning approximately 6:30 am for insubordination.

PORTABLE RADIO EQUIPMENT SIGN-OUT INDIVIDUAL	**FORM**	
Technology Department - Communications		

User Name: [redacted] **Division/Department:** WP&S

I am signing out the below radio equipment. In doing so, I agree to:

- Take full responsibility for the care, custody and control of the equipment.
- Use assigned equipment for VTA related communications only.
- Practice proper two-way radio etiquette.
- Promptly Submit a Technology Help Desk Ticket for any malfunctioning equipment.
- Return equipment to Technology upon change of work assignment.
- Immediately report loss or theft of radio equipment to the Operations Control Center and the Technology Department.
    - Complete Form AS-T-1405D, Report of Lost, Stolen or Damaged Communications Equipment.

Serial Number	Radio Equipment	Received	Returned
426CTM4486	Motorola APX 6000	7/11/19	

User Signature: [signature] Date: 7/11/19

From: [redacted]
To: [redacted]
Subject: FW: Recertification for WP&S Personnel 2020
Date: Thursday, October 29, 2020 12:04:30 PM
Attachments: image001.png

Give me a call if you can

From: [redacted]
Sent: Thursday, October 29, 2020 11:58 AM
To: [redacted]
Cc [redacted]
Subject: RE: Recertification for WP&S Personnel 2020

[redacted]:

Please send an email to the division heads (listed below) of the employees (listed below) who are refusing to attend mandatory, job-specific required training, to advise them to issue directives to the employees to comply. If they remain obstinate and refuse to comply, please assist them with the issuance of appropriate disciplines accordingly.

1. [redacted].
2. Samuel Cassidy, Substation Maintainer – [redacted]
3. [redacted]

Thanks,

[redacted]
Santa Clara Valley Transportation Authority
3331 North First Street, Building B
San Jose, CA 95134-1927
[redacted]

From: [redacted]
Sent: Thursday, October 29, 2020 11:32 AM
To: [redacted]
Cc: [redacted]
Subject: RE: Recertification for WP&S Personnel 2020

Hi Team,

[redacted] and I discussed this morning.
The list provided was reviewed by EHS, myself, our [redacted]. At the end of that review, it was determined that those listed need to have the training due to their job requirements, support from their supervisor that the training would be beneficial, and/or the fact that they are ERT

members. For ERT members, that membership is voluntary and if they would prefer not to participate any longer, then they can be removed from the list (provided there is no job requirement associated with them remaining). If someone is challenging their required participation, they need to explain why – beyond just a level of comfort. For example, a doctor's note that designates them as "high risk" and requests they be excused from onsite work and/or training. We have taken all steps to ensure the safe environment during this training and those on the list need to participate.
Please let us know your thoughts.

[redacted]
3331 North First Street, Building B
San Jose, CA 95134
[redacted]

From: [redacted]
Sent: Wednesday, October 28, 2020 5:07 PM
To: [redacted]
Cc [redacted]
Subject: RE: Recertification for WP&S Personnel 2020
Thanks, all. [redacted] and I will review the list tomorrow and advise if there are any changes to who must have the CPR certification.

From: [redacted]
Sent: Wednesday, October 28, 2020 3:59 PM
To: [redacted]
Cc: [redacted]
Subject: RE: Recertification for WP&S Personnel 2020
To add more color, I agree there is a labor relations component to it. That comes into play if and when record is established that CPR certification is an absolute requirement for the classification. My team can address that issue as needed. For now, I am not sure everyone on the list I saw needs a CPR certification for their positions.

[redacted]
Santa Clara Valley Transportation Authority
3331 North First Street, Building B
San Jose, CA 95134-1927
[redacted]

From: [redacted]
Sent: Wednesday, October 28, 2020 3:48 PM
To: [redacted]
Cc: [redacted]
Subject: RE: Recertification for WP&S Personnel 2020

Susan – Thank you for your response. A few additional comments based on your response:

- OD&T is provided a list of job classifications and is advised that ***all*** on the list are required to take CPR. We do not know what job classifications require specific training.
- Since are goal is to optimize every class for cost effectiveness, we make all classes open to all employees required to take CPR. For this year's hybrid class (due to COVID) we schedule classes as employees complete their online courses. When we have a class that is short students, [redacted] reaches out to the respective Managers/Supervisors for assistance with filling the class.
- Our goal is to complete all classes within 3 months so that expiration dates are similar.

Kind Regards,

[redacted]
Santa Clara Valley Transportation Authority
3331 North First Street, Building B
San Jose, CA 95134-1927
[redacted]

From: [redacted]
Sent: Wednesday, October 28, 2020 3:11 PM
To: [redacted]
Cc: [redacted]
Subject: Re: Recertification for WP&S Personnel 2020
[redacted]

Thank you for your response and additional details surrounding the issue. I will talk with [redacted] about this concern when I am in the office tomorrow. I still do think this is a labor relations concern especially if WP&S staff have it in their job classification to obtain or maintain specific trainings, but nonetheless I will follow up with you and your staff.
Below is an email response from [redacted] back in July on First Aid CPR.
"**My recommendation would be to first prioritize the positions that require CPR/First Aid training for thier classification**. To my knowledge, this applies only to the WPS Department. Beyond that, I would recommend training be offered to the operating Divisions first as they have more employees on-site at this time. Supervision staff and foremen should be targeted and it should be ensured that at least one person is trained in each area, during each shift. I recommend that [redacted] work with Division management [redacted] to decide how to best to ensure coverage and training."
Respectfully,

[redacted]

[redacted]

Santa Clara Valley Transportation Authority

3331 North First Street, Building B

San Jose, CA 95134-1927

[redacted]

[redacted]

From: [redacted]
Sent: Wednesday, October 28, 2020 1:50 PM
To: [redacted]
Cc: [redacted]
Subject: RE: Recertification for WP&S Personnel 2020
Good afternoon [redacted],
[redacted], you are correct that yesterday there were conversations around Substation Maintainer Sam Cassidy regarding his reluctance to attend CPR Training. (Coincidentally he also refused to attend today's Recertification for Light Rail which is also mandatory.) [redacted] and I were preparing an email yesterday to seek guidance from [redacted] (since [redacted] is on leave) but it had not gone out yet.
Since I have been overseeing CPR (2016), our protocol has not changed. Safety is responsible for identifying who is required to take CPR and OD&T works provides the resources for staff to take the training. When staff expresses concerns with taking CPR or questions why they are required to take CPR, we have always referred them to Safety. These concerns vary from physically not being able to perform CPR to emotionally not wanting to provide CPR. If Safety provides an exemption, we make a note of that.

[redacted] advises that thus far, she has had just 4 individuals reach out about CPR concerns.

1. [redacted] - Not comfortable performing CPR on anyone and has requested [redacted] obtain an exemption.
2. Samuel Cassidy, Substation Maintainer – Safety concerns surrounding being in an in-person, instructor-led class. Has also refused to take Recertification for Light Rail which is also mandatory.
3. [redacted] – No reason provided.
4. [redacted] – Due to pending retirement

Following past protocol, we request Safety reach out to each individual and make a decision on a case by case basis. I would keep in mind the following:

- To date, 96 employees have completed the ***in person*** portion of CPR Training. We have received much positive feedback.
- If you advise one Substation Maintainer that they do not need CPR, you can expect 7 others to follow suit. This applies to most all job classifications.
- [redacted] and I have been training at Guadalupe since early October. What we have heard from non-supervisory staff at Guadalupe is that while they continue to come to work each day, management regularly works from home sending the message that it is safe enough for non-supervisory staff but not supervisory staff.
- When reaching out to employees, it is important that Safety not only reiterate the steps VTA has made to keep the workplace safe but conveys confidence in these steps by supporting onsite work.

Please let me know if you have further questions. Otherwise, we will wait for your review and response.

Kind Regards,

[redacted]
Santa Clara Valley Transportation Authority
3331 North First Street, Building B
San Jose, CA 95134-1927
[redacted]

From: [redacted]
Sent: Wednesday, October 28, 2020 11:36 AM
To: [redacted]
Subject: FW: Recertification for WP&S Personnel 2020

Any history of anyone refusing to get trained because of COVID.

[redacted]

Santa Clara Valley Transportation Authority
3331 North First Street, Building B
San Jose, CA 95134-1927

[redacted]

From: [redacted]
Sent: Wednesday, October 28, 2020 9:47 AM
To: [redacted]
Cc: [redacted]
Subject: Fw: Recertification for WP&S Personnel 2020

[redacted]

I was out yesterday and it appears there was a string of emails surrounding First Aid & CPR certification, in particular an employee from the WP&S team which is refusing to take the training due to the current pandemic with COVID 19.
I gather this will not be the first employee who may refuse to take the training due to the concerns. I know [redacted] has been coordinating all the training and advising the various employees who are in need of certification or recertification. Safety precautions have been put in place by having 3-4 hour on-line self paced portion and 2 hour in class portion with small class sizes of about 10 to accommodate for social distancing.
How would you like us to handle this type of situation? Refer them to HR department to be handled case by case? Any feedback would be much appreciated.
Respectfully,

[redacted]

Santa Clara Valley Transportation Authority

3331 North First Street, Building B

San Jose, CA 95134-1927

[redacted]

From: [redacted]

Sent: Tuesday, October 27, 2020 12:04 PM
To: [redacted]
Cc: [redacted]
Subject: RE: Recertification for WP&S Personnel 2020
Hi [redacted]
Please, advise.
Regards,
[redacted]

From: [redacted]
Sent: Tuesday, October 27, 2020 11:06 AM
To: [redacted]
Cc: [redacted]
Subject: FW: Recertification for WP&S Personnel 2020
Please, advise.

From: [redacted]
Sent: Tuesday, October 27, 2020 11:06 AM
To: [redacted]
Cc: [redacted]
Subject: RE: Recertification for WP&S Personnel 2020
[redacted]
I did remind Sam of his job requirements and being an essential employee. He still doesn't want to attend the class in a closed room. I am planning to bring this issue in today's ATU/VTA meeting.
Regards,
[redacted]

From: [redacted]
Sent: Tuesday, October 27, 2020 10:15 AM
To: [redacted]
Cc: [redacted]
Subject: RE: Recertification for WP&S Personnel 2020
[redacted]
Please address this issue, you may want to remind Sam of the requirements of the position and being an Essential Employee.
[redacted]

From: [redacted]
Sent: Tuesday, October 27, 2020 10:03 AM
To: [redacted]
Cc: [redacted]
Subject: RE: Recertification for WP&S Personnel 2020
[redacted]
Sam has refused to attend the recert class tomorrow, unless it is outdoor.
Regards,
[redacted]

From: [redacted]
Sent: Friday, October 23, 2020 8:50 AM
To: [redacted]
Cc: [redacted]
Subject: RE: Recertification for WP&S Personnel 2020

[redacted]

Please, let me know the day you have the least students. Sam might not agree to attend the class with other employees for covid reasons.
Thanks.

From: [redacted]
Sent: Friday, October 23, 2020 8:38 AM
To: [redacted]
Subject: RE: Recertification for WP&S Personnel 2020

Thank you

From: [redacted]
Sent: Friday, October 23, 2020 8:33 AM
To: [redacted]
Cc: [redacted]
Subject: RE: Recertification for WP&S Personnel 2020

Hi [redacted]
Day Shift:
Tuesday:

1. [redacted]
2. [redacted]

Wednesday:

1. [redacted]
2. Sam Cassidy

Thanks,

[redacted]

From: [redacted]
Sent: Friday, October 23, 2020 8:04 AM
To: [redacted]
Cc: [redacted]
Subject: FW: Recertification for WP&S Personnel 2020

Good morning,
Next week I have scheduled recert for your staff. You were advised on August 26, 2020. Please let me know what days your staff will be attending along with their names. Thank you.
Regards,

[redacted]

95 W Younger Avenue, Building I
San Jose, CA 95110

[redacted]

From: [redacted]
Sent: Wednesday, August 26, 2020 10:38 AM
To: [redacted]

Subject: Recertification for WP&S Personnel 2020

August 26, 2020

Good morning,

Recertification classes will begin Tuesday, September 29th, 2020. Classes will be limited to five students per class. The recertification calendar is attached. Please respond with the dates your staff will be attending along with their name and badge. I will send out notifications as classes fill up. Let me know if you have any questions.

Lastly, please advise your staff to report to our new location at 95 West Younger Avenue, Building I, and to comply with the covid-19 precautions including, but not limited to, wearing a face mask and the social distancing protocols. The Light Rail Operating Rulebook, Driver's License, and Medical Card are required for recertification class.

Thank you,

[redacted]

95 W Younger Avenue, Building I
San Jose, CA 95110

[redacted]

From: [redacted]
To: [redacted]
Cc: [redacted]
Subject: FW: Sam Cassidy - First Aid, CPR, and AED Skills Reinforcement Training
Date: Tuesday, October 27, 2020 12:03:13 PM
Attachments: image001.png
image002.png
image003.png
image004.png

[redacted]
Sam Cassidy is a Substation Maintainer. He is a hard working employee. He has refused to attend this class because of COVID threat. [redacted] discussed this issue with [redacted], she advised to bring this issue to your attention.
Regards,
[redacted]

From: [redacted]
Sent: Tuesday, October 27, 2020 11:05 AM
To: [redacted]
Cc: [redacted]
Subject: FW: Sam Cassidy - First Aid, CPR, and AED Skills Reinforcement Training
Hi [redacted],
Please, advise.
Regards,
[redacted]

From: [redacted]
Sent: Tuesday, October 27, 2020 10:58 AM
To: [redacted]
Cc: [redacted]
Subject: RE: Sam Cassidy - First Aid, CPR, and AED Skills Reinforcement Training
[redacted] is in a meeting right now but [redacted] just followed up and [redacted] will follow back up with her, you and [redacted]
Appreciate you staying on top of this.
[redacted]
Santa Clara Valley Transportation Authority
3331 North First Street, Building B
San Jose, CA 95134-1927
[redacted]

CONFIDENTIALITY NOTICE:
The contents of this email message and any attachments are intended solely for the addressee(s) and may contain confidential and/or privileged information and may be legally protected from disclosure. If you are not the intended recipient of this message or their agent, or if this message has been addressed to you in error, please immediately alert the sender by reply email and then delete this message and any attachments. If you are not the intended recipient, you are hereby notified that any use, dissemination, copying, or storage of this message or its attachments is prohibited.

From: [redacted]
Sent: Tuesday, October 27, 2020 10:55 AM
To: [redacted]
Cc: [redacted]
Subject: RE: Sam Cassidy - First Aid, CPR, and AED Skills Reinforcement Training
[redacted]
I am waiting for [redacted] and [redacted] for further instructions.
Regards,
[redacted]

From: [redacted]

Sent: Tuesday, October 27, 2020 10:12 AM
To: [redacted]
Cc: [redacted]
Subject: FW: Sam Cassidy - First Aid, CPR, and AED Skills Reinforcement Training

[redacted]

Have you take this up with Safety and recommended?

[redacted]

From: [redacted]
Sent: Wednesday, October 21, 2020 11:11 AM
To: [redacted]
Cc: [redacted]
Subject: RE: Sam Cassidy - First Aid, CPR, and AED Skills Reinforcement Training

All – This will need to be taken up with Safety as they provide us the job classifications that require CPR and we facilitate the classes. We are meeting all of the County requirements with regards to safeguarding our staff.

[redacted]

Santa Clara Valley Transportation Authority
3331 North First Street, Building B
San Jose, CA 95134-1927

[redacted]

From: [redacted]
Sent: Wednesday, October 21, 2020 11:02 AM
To: [redacted]
Cc: [redacted]

[redacted]

Subject: Sam Cassidy - First Aid, CPR, and AED Skills Reinforcement Training
Importance: High

Hi [redacted]

I spoke to [redacted] about his position with regard to not attending the skills reinforcement class for First Aid, CPR, and AED Blending Training. Here is summarization of my conversations with Sam. On Friday, 10/16 Sam contacted me to confirm the safety measures that VTA has implemented to keep employees safe during in person classes. I outlined the protocols in the Return to Work Playbook, and the county guidelines surrounding density limitations. [redacted] wanted further information about how the number of allowable persons in a particular space are being calculated. I looped in [redacted] to confirm that information and he did provide us with the formula. Following that, [redacted] proceeded to register, via SuccessFactors for skills class, which was scheduled today at River Oaks at 9:30 am. This morning, you informed me that he decided not to attend. I spoke to [redacted] and he stated that he has been on the fence about attending an in person class from the start. He took into consideration all the information provided to him and ultimately, for his own safety concerns, he does not feel comfortable attending. Finally, he mentioned that if school districts are not fully open to having students in class and are still practicing distance learning, he doesn't feel 100% safe in an in person classroom setting.
Please let me know if you have any questions.
Thank you,

[redacted]

Santa Clara Valley Transportation Authority
3331 North First Street, Building B-1
San Jose, CA 95134-1927

[redacted]

From: [redacted]
Sent: Wednesday, October 21, 2020 9:13 AM
To: [redacted]
Cc: [redacted]
Subject: RE: In-person First Aid, CPR, and AED Skills Reinforcement Training
I asked him to call you. You can also call him on his cell [redacted]

From: [redacted]
Sent: Wednesday, October 21, 2020 8:53 AM
To: [redacted]
Cc: [redacted]
Subject: RE: In-person First Aid, CPR, and AED Skills Reinforcement Training
Good morning [redacted]
Our records show that Sam's certification expired on 4/19/2020. After COVID, everyone received an extension of 120 days, therefore he technically expired in 8/1/2020.
Could you have Sam reach out to me directly?
Let me know if you have any other questions.
Thank you,

[redacted]

Santa Clara Valley Transportation Authority
3331 North First Street, Building B-1
San Jose, CA 95134-1927
[redacted]

From: [redacted]
Sent: Wednesday, October 21, 2020 8:28 AM
To: [redacted]
Cc: [redacted]
Subject: RE: In-person First Aid, CPR, and AED Skills Reinforcement Training
Hi [redacted]
Sam is refusing to attend the class. When did his CPR certification expire?

From: [redacted]
Sent: Tuesday, October 20, 2020 9:38 AM
To: [redacted]
Cc: [redacted]
Subject: RE: In-person First Aid, CPR, and AED Skills Reinforcement Training
Good morning [redacted]
Thank you for the heads up.

[redacted]

Santa Clara Valley Transportation Authority
3331 North First Street, Building B-1
San Jose, CA 95134-1927
[redacted]

From [redacted]
Sent: Tuesday, October 20, 2020 7:59 AM
To: [redacted]
Cc: [redacted]
Subject: RE: In-person First Aid, CPR, and AED Skills Reinforcement Training
Hi [redacted]
[redacted] will be attending class today.
[redacted] will be attending class tomorrow.
Thanks,
[redacted]

From: [redacted]
Sent: Wednesday, October 14, 2020 11:06 AM
To: [redacted]
Cc: [redacted]
Subject: Re: In-person First Aid, CPR, and AED Skills Reinforcement Training
No problem, I have added [redacted] & [redacted] to the 10/20 class at 9:30 AM and [redacted]
& Samuel Cassidy to the 10/21 class at 9:30 AM.
Thank you,
[redacted]

From: [redacted]
Sent: Wednesday, October 14, 2020 10:21 AM
To: [redacted]
Subject: RE: In-person First Aid, CPR, and AED Skills Reinforcement Training
Sorry, yes.

From: [redacted]
Sent: Wednesday, October 14, 2020 10:09 AM
To: [redacted]
Subject: Re: In-person First Aid, CPR, and AED Skills Reinforcement Training
Hi [redacted]
I am a little confused did you mean class 948108 on 10/20/2020 and 948110 on 10/21/2020?
- [redacted]

From: [redacted]
Sent: Wednesday, October 14, 2020 9:28 AM
To: [redacted]
Subject: RE: In-person First Aid, CPR, and AED Skills Reinforcement Training
[redacted]
Please, schedule [redacted] and [redacted] for class 94810 at 9:30am on 9/20/20.
Schedule [redacted] and Samual Cassidy # 948110 at 9::30 on 9/21/20.
Thanks,
[redacted]

From: [redacted]
Sent: Wednesday, October 14, 2020 9:18 AM
To: [redacted]
Subject: Re: In-person First Aid, CPR, and AED Skills Reinforcement Training
Good Morning [redacted]
I've attached an image below showing available class times. Please note the online portion of this training must be completed before an employee can take the instructor-led class.
Thanks,
[redacted]

From: [redacted]
Sent: Wednesday, October 14, 2020 6:40 AM
To: [redacted]
Subject: RE: In-person First Aid, CPR, and AED Skills Reinforcement Training
Hi [redacted]
Please, email dates and time available for classes. So, I can schedule the staff to take the class.
Thanks,
[redacted]

From: [redacted]
Sent: Tuesday, October 13, 2020 1:37 PM
To: [redacted]
Cc: [redacted]
Subject: In-person First Aid, CPR, and AED Skills Reinforcement Training
Good Afternoon,
We have added additional instructor-led courses for First Aid, CPR, and AED Skills Reinforcement Training into SuccessFactors. We welcome you and your employees to register for the available classes.
Please note, one must have already completed the online portion of this training before they can enroll in the instructor-led class.
In addition, we need a minimum of 10 students enrolled to hold a class. All classes are subject to cancelation due to low registration.
Thank you,

[redacted]
Santa Clara Valley Transportation Authority
3331 North First Street, Building B
San Jose, CA 95134-1927
[redacted]

[redacted]

From: [redacted]
Sent: Friday, February 19, 2021 7:47 AM
To: [redacted]
Subject: FW: Samuel Cassidy #747 - Unprofessional radio communication and refusing an instruction from OCC

From: Cassidy, Samuel <Samuel.Cassidy@vta.org>
Sent: Wednesday, February 10, 2021 11:44 AM
To: [redacted]
Cc: [redacted]
Subject: Re: Samuel Cassidy #747 - Unprofessional radio communication and refusing an instruction from OCC

My actions did not arise from a vacuum. This was a response due to an abuse of authority by the WPS operations manager, who did not post the vacation sign-up, which led to it being canceled. Abuse grows in the dark, my intent was to bring that abuse to light by being vocal about it so others are aware of it.
Sam Cassidy

Sent from my iPhone

On Feb 10, 2021, at 11:04 AM, [redacted] wrote:

> Hi [redacted]
> As per our meeting yesterday, Sam was counseled on his code of conduct. Just want to remind and reiterate on our agreement/conclusion, this behavior by Sam must not be repeated again. Any similar violation will lead to disciplinary action.
> Regards,
> [redacted]
>
> **From:** [redacted]
> **Sent:** Tuesday, February 9, 2021 9:08 AM
> **To:** [redacted]
> **Cc:** [redacted]
> **Subject:** Samuel Cassidy #747 - Unprofessional radio communication and refusing an instruction from OCC
> Good morning [redacted]
> Per our conversation, at 0833 today, 2/9/21, Samuel Cassidy #747 notified OCC that he

was at Sub 4 and the Rail Controller copied his traffic. He allegedly did not here her response and pressed his EA. When asked if he had an emergency, he responded that he pressed his EA because his radio traffic was not answered. I became aware of the situation and requested a 10-21, which he refused and communicated unprofessionally and unnecessarily on the radio. The WAV file is attached. Please make sure this situation is addressed in a timely manner.

Thank you,

[redacted]

Santa Clara Valley Transportation Authority
101 W. Younger Avenue, Building A
San Jose, CA 95110-1719

[redacted]

From: [redacted]
To: [redacted]
Subject: Fwd: Update on CPR Training
Date: Monday, November 30, 2020 3:13:19 PM
Attachments: image002.png
image002.png
image002.png
image002.png

FYI

Sent from my iPhone

Begin forwarded message:

From: "[redacted]
Date: November 30, 2020 at 3:05:17 PM PST
To: "[redacted]
Cc: [redacted]
Subject: Update on CPR Training

Good Afternoon [redacted]
Below is an update for you regarding staff who expressed reservations with taking CPR training. See my responses in red. (Original email below.)

1. [redacted] - **Is willing to complete this mandatory training and will receive a training key from OD&T within the next 14 days. As River Oaks staff, he is in the next phase.**
2. Samuel Cassidy, Substation Maintainer – Safety concerns surrounding being in an in-person, instructor-led class. Has also refused to take Recertification for Light Rail which is also mandatory. **Per his supervisor, no progress made.**
3. [redacted] **Completed the training.**
4. [redacted] – **No longer with VTA.**

We are in progress of completing the training for all required staff in Operations and the first wave of ERT members. We expect to move on to River Oaks staff and the remainder of ERT members soon.
Let me know if you would like more details on any of the above information.

Thank you,

[redacted]

Santa Clara Valley Transportation Authority
3331 North First Street, Building B-1
San Jose, CA 95134-1927
[redacted]

From: [redacted]
Sent: Wednesday, October 28, 2020 1:50 PM
To: [redacted]
Cc: [redacted]
Subject: RE: Recertification for WP&S Personnel 2020

Good afternoon [redacted]

[redacted] you are correct that yesterday there were conversations around Substation Maintainer Sam Cassidy regarding his reluctance to attend CPR Training. (Coincidentally he also refused to attend today's Recertification for Light Rail which is also mandatory.) [redacted] and I were preparing an email yesterday to seek guidance from [redacted] (since [redacted] is on leave) but it had not gone out yet.

Since I have been overseeing CPR (2016), our protocol has not changed. Safety is responsible for identifying who is required to take CPR and OD&T works provides the resources for staff to take the training. When staff expresses concerns with taking CPR or questions why they are required to take CPR, we have always referred them to Safety. These concerns vary from physically not being able to perform CPR to emotionally not wanting to provide CPR. If Safety provides an exemption, we make a note of that.

[redacted] advises that thus far, she has had just 4 individuals reach out about CPR concerns.

1. [redacted] - Not comfortable performing CPR on anyone and has requested [redacted] obtain an exemption.
2. Samuel Cassidy, Substation Maintainer – Safety concerns surrounding being in an in-person, instructor-led class. Has also refused to take Recertification for Light Rail which is also mandatory.
3. [redacted] – No reason provided.
4. [redacted] – Due to pending retirement

Following past protocol, we request Safety reach out to each individual and make a decision on a case by case basis. I would keep in mind the following:

- To date, 96 employees have completed the ***in person*** portion of CPR Training. We have received much positive feedback.
- If you advise one Substation Maintainer that they do not need CPR, you can expect 7 others to follow suit. This applies to most all job classifications.
- [redacted] and I have been training at Guadalupe since early October. What we have heard from non-supervisory staff at Guadalupe is that while they continue to

come to work each day, management regularly works from home sending the message that it is safe enough for non-supervisory staff but not supervisory staff.

- When reaching out to employees, it is important that Safety not only reiterate the steps VTA has made to keep the workplace safe but conveys confidence in these steps by supporting onsite work.

Please let me know if you have further questions. Otherwise, we will wait for your review and response.

Kind Regards,

[redacted]

Santa Clara Valley Transportation Authority
3331 North First Street, Building B
San Jose, CA 95134-1927

[redacted]

From: [redacted]
Sent: Wednesday, October 28, 2020 11:36 AM
To: [redacted]
Subject: FW: Recertification for WP&S Personnel 2020

Any history of anyone refusing to get trained because of COVID.

[redacted]

Santa Clara Valley Transportation Authority
3331 North First Street, Building B
San Jose, CA 95134-1927

[redacted]

From: [redacted]
Sent: Wednesday, October 28, 2020 9:47 AM
To: [redacted]
Cc: [redacted]

Subject: Fw: Recertification for WP&S Personnel 2020

[redacted]

I was out yesterday and it appears there was a string of emails surrounding First Aid & CPR certification, in particular an employee from the WP&S team which is refusing to take the training due to the current pandemic with COVID 19.

I gather this will not be the first employee who may refuse to take the training due to the concerns. I know [redacted] has been coordinating all the training and advising the various employees who are in need of certification or recertification. Safety precautions have been put in place by having 3-4 hour on-line self paced portion and 2 hour in class portion with small class sizes of about 10 to accommodate for social distancing.

How would you like us to handle this type of situation? Refer them to HR department to be handled case by case? Any feedback would be much appreciated.

Respectfully,

[redacted]

Santa Clara Valley Transportation Authority
3331 North First Street, Building B
San Jose, CA 95134-1927

[redacted]

From: [redacted]
Sent: Tuesday, October 27, 2020 12:04 PM
To: [redacted]
Cc: [redacted]
Subject: RE: Recertification for WP&S Personnel 2020

Hi [redacted]

Please, advise.

Regards,

[redacted]

From: [redacted]
Sent: Tuesday, October 27, 2020 11:06 AM
To: [redacted]
Cc: [redacted]
Subject: FW: Recertification for WP&S Personnel 2020

Please, advise.

From: [redacted]
Sent: Tuesday, October 27, 2020 11:06 AM
To: [redacted]
Cc: [redacted]

Subject: RE: Recertification for WP&S Personnel 2020

[redacted]

I did remind Sam of his job requirements and being an essential employee. He still doesn't want to attend the class in a closed room. I am planning to bring this issue in today's ATU/VTA meeting.

Regards,

[redacted]

From: [redacted]
Sent: Tuesday, October 27, 2020 10:15 AM
To: [redacted]
Cc: [redacted]
[redacted]
Subject: RE: Recertification for WP&S Personnel 2020

[redacted],

Please address this issue, you may want to remind Sam of the requirements of the position and being an Essential Employee.

[redacted]

From: [redacted]
Sent: Tuesday, October 27, 2020 10:03 AM
To: [redacted]
Cc: [redacted]
[redacted]
Subject: RE: Recertification for WP&S Personnel 2020

[redacted]

Sam has refused to attend the recert class tomorrow, unless it is outdoor.

Regards,

[redacted]

From: [redacted]
Sent: Friday, October 23, 2020 8:50 AM
To: [redacted]
Cc: [redacted]
Subject: RE: Recertification for WP&S Personnel 2020

[redacted]

Please, let me know the day you have the least students. Sam might not agree to attend the class with other employees for covid reasons.

Thanks.

From: [redacted]
Sent: Friday, October 23, 2020 8:38 AM
To: [redacted]
Subject: RE: Recertification for WP&S Personnel 2020

Thank you

From: [redacted]
Sent: Friday, October 23, 2020 8:33 AM
To: [redacted]

Cc: [redacted]
Subject: RE: Recertification for WP&S Personnel 2020
Hi [redacted]
Day Shift:
Tuesday:
1. [redacted]
2. [redacted]

Wednesday:
1. [redacted]
2. Sam Cassidy

Thanks,
[redacted]

From: [redacted]
Sent: Friday, October 23, 2020 8:04 AM
To: [redacted]
Cc: [redacted]
Subject: FW: Recertification for WP&S Personnel 2020
Good morning,
Next week I have scheduled recert for your staff. You were advised on August 26, 2020.
Please let me know what days your staff will be attending along with their names.
Thank you.
Regards,
[redacted]
95 W Younger Avenue, Building I
San Jose, CA 95110
[redacted]

From: [redacted]
Sent: Wednesday, August 26, 2020 10:38 AM
To: [redacted]

[redacted]
[redacted]
[redacted]
Cc: [redacted]
[redacted]
[redacted]
[redacted]
Subject: Recertification for WP&S Personnel 2020
August 26, 2020
Good morning,

Recertification classes will begin Tuesday, September 29th, 2020. Classes will be limited to five students per class. The recertification calendar is attached. Please respond with the dates your staff will be attending along with their name and badge. I will send out notifications as classes fill up. Let me know if you have any questions. Lastly, please advise your staff to report to our new location at 95 West Younger Avenue, Building I, and to comply with the covid-19 precautions including, but not limited to, wearing a face mask and the social distancing protocols. The Light Rail Operating Rulebook, Driver's License, and Medical Card are required for recertification class.

Thank you,

[redacted]
95 W Younger Avenue, Building I
San Jose, CA 95110
[redacted]

From: [redacted]
To: [redacted]
Cc: [redacted]
Subject: Re: First Aid, CPR, and AED Blended Training Progress for WP&S
Date: Friday, November 13, 2020 6:28:01 AM
Attachments: image001.png
image002.png
image003.png

Hi [redacted]
Thank you for your response.

[redacted]-Moving forward, please send direct all staff to send requests to Employee Relations. As I stated to [redacted] this allows us to keep track of all requests and determine how we will respond to each one.

Thank you both.

[redacted]

On Nov 13, 2020, at 5:59 AM, [redacted] > wrote:

Hi [redacted]
I got permission from [redacted] couple of weeks ago to work with [redacted] to find a solution. He asked me for the list of Power Department, who have completed the training. In the future, I will forward the request to employee relations.
Thanks,
[redacted]

From: [redacted]
Sent: Thursday, November 12, 2020 1:22 PM
To [redacted]
Subject: FW: First Aid, CPR, and AED Blended Training Progress for WP&S
FYI!

From: [redacted]
Sent: Monday, November 9, 2020 11:46 AM
To: [redacted]
Subject: FW: First Aid, CPR, and AED Blended Training Progress for WP&S
Good morning [redacted]
Below is a First Aid, CPR, and AED Blending Training progress status report for your employees. All but Samuel Cassidy and [redacted] are 100% complete with both portions of the training. Thank you for ensuring that your staff completed the training. Your support if very much appreciated!
Let me know if you need anything further.
Thank you,
[redacted]

Santa Clara Valley Transportation Authority
3331 North First Street, Building B-1
San Jose, CA 95134-1927
[redacted]
<image001.png>

From: [redacted]
Sent: Monday, November 9, 2020 10:49 AM
To: [redacted]
Subject: RE: First Aid, CPR, and AED Blended Training Progress for WP&S

Badge	Last Name	First Name	Job Title	Shift	Days Off	

[redacted]			PFL	6-1430	F/S	100% Complete
			PFL	22-3030	F/S	100% Complete
10391	Cassidy	Samuel	LSM	6-1430	S/M	
[redacted]			LOW	6-1430	S/M	
			LSM	6-1430	F/S	100% Complete
			LOW	22-3030	S/M	100% Complete
			LSM	22-3030	S/S	100% Complete
		r	LSM	22-3030	F/S	100% Complete
			LSM	6-1430	S/M	100% Complete
			LSM	14-2230	F/S	100% Complete
			LOW	22-3030	F/S	100% Complete
			LOW	22-3030	S/M	100% Complete
			LSM	22-3030	S/M	100% Complete
		d	LSM	14-2230	S/M	100% Complete
			LOW	22-3030	F/S	100% Complete
			LOW	22-3030	F/S	100% Complete
			LOW	22-3030	F/S	100% Complete

From: [redacted]
Sent: Monday, November 9, 2020 8:38 AM
To: [redacted]
Subject: RE: First Aid, CPR, and AED Blended Training Progress for WP&S

Good morning [redacted]

Yes I can. Let me request an updated report right now.

Thank you,

[redacted]

Santa Clara Valley Transportation Authority
3331 North First Street, Building B-1
San Jose, CA 95134-1927
[redacted]

From: [redacted]
Sent: Monday, November 9, 2020 5:38 AM
To: [redacted]

Subject: RE: First Aid, CPR, and AED Blended Training Progress for WP&S
Hi [redacted]
Could you please send me another report today?
Thanks,
[redacted]

From: [redacted]
Sent: Friday, November 6, 2020 10:02 AM
To: [redacted]
Subject: Re: First Aid, CPR, and AED Blended Training Progress for WP&S
[redacted] - I will run another report which will be up to date and send you another update. My apologies.
Thank you,

[redacted]

[redacted]

Santa Clara Valley Transportation Authority
3331 North First Street, Building B-1
San Jose, CA 95134-1927
[redacted]

From: [redacted]
Sent: Friday, November 6, 2020 9:57 AM
To: [redacted]
Subject: Re: First Aid, CPR, and AED Blended Training Progress for WP&S
Because they haven't completed that part, which is the in-person part. Is there an error?

[redacted]

[redacted]

Santa Clara Valley Transportation Authority
3331 North First Street, Building B-1
San Jose, CA 95134-1927
[redacted]

From: [redacted]
Sent: Friday, November 6, 2020 9:52 AM
To: [redacted]
Subject: FW: First Aid, CPR, and AED Blended Training Progress for WP&S
Why does it say Skills parts not complete for all employees?

From: [redacted]
Sent: Friday, November 6, 2020 9:10 AM
To: [redacted]
Subject: First Aid, CPR, and AED Blended Training Progress for WP&S
Good morning [redacted]
See attached. The classes listed below on 11/12 need participants. Can your employees enroll in one of the classes listed below?
<image002.png>

They have all completed the online portion, with the exception of [redacted]
Please advise and thank you!

[redacted]

[redacted]

Santa Clara Valley Transportation Authority
3331 North First Street, Building B-1
San Jose, CA 95134-1927

[redacted]

From: [redacted]
Sent: Friday, November 6, 2020 7:05 AM
To: [redacted]
Subject: CPR Skill Enforcement class

Hi [redacted]

Please, confirm every one except Sam has taken CPR skills class.

Thanks,

[redacted]
101 W. younger Ave Bldg. B
San Jose ca 95110
[redacted]

<image003.png>

From: [redacted]
To: [redacted]
Cc: [redacted]
Subject: RE: Hi-rail Recertification Practical Training WPS
Date: Wednesday, January 27, 2021 10:13:47 AM

[redacted]

I have spoken directly with Mr. Cassidy. He has agreed to attend training with the LRMT Dept. if he is sequestered in a classroom by himself for a limited (no more then sixty minutes) time. I will provide him the required PowerPoint presentation remotely through Microsoft Teams. The second component of the training is a hands on/practical activity outside of the classroom. He has stated he will not require any additional accommodations outside of standard COVD-19 protocols to complete that portion of the training.
The Light Rail Maintenance Training Department will not be administering his Hi-rail Rectification Practical Course until Sam has attended and successfully completed his required training administered by the Light Rail Technical Training Department.
Thank you,

[redacted]
101 West Younger Avenue
Building H
San Jose, Ca 95110
[redacted]

From: [redacted]
Sent: Tuesday, January 26, 2021 7:33 AM
To: [redacted]
Cc: [redacted]
Subject: RE: Hi-rail Recertification Practical Training WPS

Hi [redacted]
Sam won't go inside the classroom. Please, arrange the recert class outdoor.
Thanks,

[redacted]

From: [redacted]
Sent: Tuesday, January 26, 2021 6:44 AM
To: [redacted]
Cc: Cassidy, Samuel <Samuel.Cassidy@vta.org>; [redacted]
Subject: RE: Hi-rail Recertification Practical Training WPS

Hi [redacted]
[redacted] and Sam will attend the following class.
Hi-rail Re-certification Practical Power
Tuesday, February 2, 2021
Location: H1 and Yard
10:30am - 1:00pm
Thanks,

[redacted]

From: [redacted]
Sent: Thursday, January 21, 2021 2:42 PM
To: [redacted]
Cc: [redacted]
Subject: Hi-rail Recertification Practical Training WPS

For your consideration,

Hi-rail Recertification Practical Training with Light Rail Maintenance Training has the scheduled offerings listed at the dates and times listed below in Building H Classroom H1. Please assign your staff to one of the classes listed below.

Contact Light Rail Maintenance Training if you have any questions, comments or concerns related to the training the LRMT department is required to provide.

Week 1
Hi-rail Re-certification Practical Track
Tuesday, January 26, 2021
Location: H1 and Yard
7:00am - 9:30am
Hi-rail Re-certification Practical Power
Tuesday, January 26, 2021
Location: H1 and Yard
10:30am - 1:00pm
Hi-rail Re-certification Practical Power
Wednesday, January 27, 2021
Location: H1 and Yard
4:00am - 6:30am
Hi-rail Re-certification Practical Power
Wednesday, January 27, 2021
Location: H1 and Yard
7:00am - 9:30am
Hi-rail Re-certification Practical Track
Thursday, January 28, 2021
Location: H1 and Yard
4:00am - 6:30am
Hi-rail Re-certification Practical Track
Thursday, January 28, 2021
Location: H1
7:00am - 9:30am
Week 2
Hi-rail Re-certification Practical Power
Tuesday, February 2, 2021
Location: H1 and Yard
10:30am - 1:00pm

Hi-rail Re-certification Practical Track
Tuesday, February 2, 2021
Location: H1 and Yard
2:00pm - 4:30pm
Hi-rail Re-certification Practical Power
Wednesday, February 3, 2021
Location: H1 and Yard
4:00am - 6:30am
Hi-rail Re-certification Practical Power
Wednesday, February 3, 2021
Location: H1 and Yard
7:00am - 9:00am
Hi-rail Re-certification Power and/or Track
Thursday, February 4, 2021
Location: H1 and Yard
4:00am - 6:30am

Hi-rail Re-certification Power and/or Track
Thursday, February 4, 2021
Location: H1 and Yard
7:00am - 9:30am
The maximum is four people per class.
Regards,

[redacted]
Santa Clara Valley Transportation Authority
101 West Younger Ave., Building H
San Jose, CA 95110
[redacted]

From: [redacted]
To: [redacted]
Subject: RE: Recertification for WP&S Personnel 2020
Date: Thursday, October 29, 2020 8:42:14 AM

Hi [redacted]

His ROW certification expires on December 30th. His CPR certification already expired. He is a great worker. For your information I already have shortage of employees.

From: [redacted]
Sent: Wednesday, October 28, 2020 5:18 PM
To: [redacted]
Cc: [redacted]
Subject: Re: Recertification for WP&S Personnel 2020

Hi [redacted]

My apologies for not getting back to you. Let me discuss with my. Is and I will get back to you.

[redacted]

Sent from my iPhone

> On Oct 27, 2020, at 12:04 PM, [redacted] wrote:
>
> Hi [redacted]
> Please, advise.
> Regards,
> [redacted]
>
> ---
>
> **From:** [redacted]
> **Sent:** Tuesday, October 27, 2020 11:06 AM
> **To:** [redacted]
> **Cc:** [redacted]
> **Subject:** FW: Recertification for WP&S Personnel 2020
> Please, advise.
>
> ---
>
> **From:** [redacted]
> **Sent:** Tuesday, October 27, 2020 11:06 AM
> **To:** [redacted]
> **Cc:** [redacted]
> [redacted]
> **Subject:** RE: Recertification for WP&S Personnel 2020
> [redacted]
> I did remind Sam of his job requirements and being an essential employee. He still doesn't want to attend the class in a closed room. I am planning to bring this issue in today's ATU/VTA meeting.
> Regards,
> [redacted]

From: [redacted]
Sent: Tuesday, October 27, 2020 10:15 AM
To: [redacted]
Cc: [redacted]
[redacted]
Subject: RE: Recertification for WP&S Personnel 2020
[redacted]
Please address this issue, you may want to remind Sam of the requirements of the position and being an Essential Employee.
[redacted]

From: [redacted]
Sent: Tuesday, October 27, 2020 10:03 AM
To: [redacted]
Cc: [redacted]
[redacted]
Subject: RE: Recertification for WP&S Personnel 2020
[redacted]
Sam has refused to attend the recert class tomorrow, unless it is outdoor.
Regards,
[redacted]

From: [redacted]
Sent: Friday, October 23, 2020 8:50 AM
To: [redacted]
Cc: [redacted]
Subject: RE: Recertification for WP&S Personnel 2020
[redacted]
Please, let me know the day you have the least students. Sam might not agree to attend the class with other employees for covid reasons.
Thanks.

From: [redacted]
Sent: Friday, October 23, 2020 8:38 AM
To: [redacted]
Subject: RE: Recertification for WP&S Personnel 2020
Thank you

From: [redacted]
Sent: Friday, October 23, 2020 8:33 AM
To: [redacted]
Cc: [redacted]
Subject: RE: Recertification for WP&S Personnel 2020
Hi [redacted]
Day Shift:
Tuesday:

1. [redacted]
2. [redacted]

Wednesday:

1. [redacted]
2. Sam Cassidy

Thanks,

[redacted]

From: [redacted]
Sent: Friday, October 23, 2020 8:04 AM
To: [redacted]
Cc: [redacted]
Subject: FW: Recertification for WP&S Personnel 2020

Good morning,

Next week I have scheduled recert for your staff. You were advised on August 26, 2020. Please let me know what days your staff will be attending along with their names.

Thank you.

Regards,

[redacted]

95 W Younger Avenue, Building I
San Jose, CA 95110

[redacted]

<image001.png>

From: [redacted]
Sent: Wednesday, August 26, 2020 10:38 AM
To: [redacted]

Subject: Recertification for WP&S Personnel 2020

August 26, 2020

Good morning,

Recertification classes will begin Tuesday, September 29th, 2020. Classes will be

limited to five students per class. The recertification calendar is attached. Please respond with the dates your staff will be attending along with their name and badge. I will send out notifications as classes fill up. Let me know if you have any questions. Lastly, please advise your staff to report to our new location at 95 West Younger Avenue, Building I, and to comply with the covid-19 precautions including, but not limited to, wearing a face mask and the social distancing protocols. The Light Rail Operating Rulebook, Driver's License, and Medical Card are required for recertification class.

Thank you,

[redacted]

95 W Younger Avenue, Building I
San Jose, CA 95110
[redacted]

From: [redacted]
To: [redacted]
Subject: RE: Recertification for WP&S Personnel 2020
Date: Thursday, October 29, 2020 9:26:20 AM
Attachments: image001.png

Is the recert required? If its part of his job and its safe, we should require him to be there. We are essential workforce. If he refuses, we will have to take it from there. Would a call to [redacted] be helpful?

From: [redacted]
Sent: Thursday, October 29, 2020 8:48 AM
To: [redacted]
Subject: RE: Recertification for WP&S Personnel 2020
Sam Cassidy, a substation maintainer at WPS.

From: [redacted]
Sent: Thursday, October 29, 2020 8:37 AM
To: [redacted]
Subject: RE: Recertification for WP&S Personnel 2020
If there is proper social distancing and PPE, he should attend the class as scheduled. Who is the employee?

From: [redacted]
Sent: Wednesday, October 28, 2020 5:19 PM
To: [redacted]
Subject: Fwd: Recertification for WP&S Personnel 2020

Hi [redacted]
Please advise how the supervisor should proceed with this issue.
[redacted]

Begin forwarded message:

> **From:** "[redacted]
> **Date:** October 27, 2020 at 12:04:34 PM PDT
> **To:** "[redacted]
> **Cc:** "[redacted]
> [redacted]
> **Subject: RE: Recertification for WP&S Personnel 2020**
>
> Hi [redacted]
> Please, advise.
> Regards,
> [redacted]
>
> **From:** [redacted]
> **Sent:** Tuesday, October 27, 2020 11:06 AM
> **To:** [redacted]

Cc: [redacted]
Subject: FW: Recertification for WP&S Personnel 2020
Please, advise.

From: [redacted]
Sent: Tuesday, October 27, 2020 11:06 AM
To: [redacted]
Cc: [redacted]
[redacted]
Subject: RE: Recertification for WP&S Personnel 2020
[redacted]
I did remind Sam of his job requirements and being an essential employee. He still doesn't want to attend the class in a closed room. I am planning to bring this issue in today's ATU/VTA meeting.
Regards,
[redacted]

From: [redacted]
Sent: Tuesday, October 27, 2020 10:15 AM
To: [redacted]
Cc: [redacted]
[redacted]
Subject: RE: Recertification for WP&S Personnel 2020
[redacted]
Please address this issue, you may want to remind Sam of the requirements of the position and being an Essential Employee.
[redacted]

From: [redacted]
Sent: Tuesday, October 27, 2020 10:03 AM
To: [redacted]
Cc: [redacted]
[redacted]
Subject: RE: Recertification for WP&S Personnel 2020
[redacted]
Sam has refused to attend the recert class tomorrow, unless it is outdoor.
Regards,
[redacted]

From: [redacted]
Sent: Friday, October 23, 2020 8:50 AM
To: [redacted]
Cc: [redacted]
Subject: RE: Recertification for WP&S Personnel 2020
[redacted]
Please, let me know the day you have the least students. [redacted] might not agree to attend the class with other employees for covid reasons.
Thanks.

From: [redacted]
Sent: Friday, October 23, 2020 8:38 AM
To: [redacted]
Subject: RE: Recertification for WP&S Personnel 2020
Thank you

From: [redacted]
Sent: Friday, October 23, 2020 8:33 AM
To: [redacted]
Cc: [redacted]
Subject: RE: Recertification for WP&S Personnel 2020
Hi [redacted]
Day Shift:
Tuesday:

1. [redacted]
2. [redacted]

Wednesday:

1. [redacted]
2. Sam Cassidy

Thanks,
[redacted]

From: [redacted]
Sent: Friday, October 23, 2020 8:04 AM
To: [redacted]
Cc: [redacted]
Subject: FW: Recertification for WP&S Personnel 2020
Good morning,
Next week I have scheduled recert for your staff. You were advised on August 26, 2020.
Please let me know what days your staff will be attending along with their names.
Thank you.
Regards,
[redacted]
95 W Younger Avenue, Building I
San Jose, CA 95110
[redacted]

From: [redacted]
Sent: Wednesday, August 26, 2020 10:38 AM
To: [redacted]

[redacted]

Cc: [redacted]

Subject: Recertification for WP&S Personnel 2020

August 26, 2020

Good morning,

Recertification classes will begin Tuesday, September 29th, 2020. Classes will be limited to five students per class. The recertification calendar is attached. Please respond with the dates your staff will be attending along with their name and badge. I will send out notifications as classes fill up. Let me know if you have any questions. Lastly, please advise your staff to report to our new location at 95 West Younger Avenue, Building I, and to comply with the covid-19 precautions including, but not limited to, wearing a face mask and the social distancing protocols. The Light Rail Operating Rulebook, Driver's License, and Medical Card are required for recertification class.

Thank you,

[redacted]

95 W Younger Avenue, Building I
San Jose, CA 95110

[redacted]

From: [redacted]
To: [redacted]
Cc: [redacted]
Subject: Re: Recertification for WP&S Personnel 2020
Date: Monday, January 25, 2021 1:00:24 PM

[redacted]

Let's move forward with the recertification for the crew to report in Building H. [redacted] can recertify three persons, certified, i think we should move on that.
[redacted] will be back to normal hours Friday. We can coordinate this remote training then.
[redacted] is currently working 10:30pm - 6:30am, we appreciate your patience.

[redacted] we will not need to block a classroom for this training, just waiting for [redacted] to identify a date that he is able to accommodate Sam's [redacted] request.

From: [redacted]
Sent: Monday, January 25, 2021 11:21 AM
To: [redacted]>
Cc: [redacted]
Subject: FW: Recertification for WP&S Personnel 2020
Hi [redacted]
Sam has refused to take any indoor classes due to Covid reasons. [redacted] had agreed to bring laptops in building B. Please, let me know if it is possible.
Thanks,
[redacted]

From: [redacted]>
Sent: Wednesday, October 28, 2020 5:18 PM
To: [redacted]
Cc: [redacted]
Subject: Re: Recertification for WP&S Personnel 2020
Hi [redacted]
My apologies for not getting back to you. Let me discuss with my. Is and I will get back to you.
[redacted]

Sent from my iPhone

> On Oct 27, 2020, at 12:04 PM, [redacted] wrote:
>
> Hi [redacted]
> Please, advise.
> Regards,

[redacted]

From: [redacted]
Sent: Tuesday, October 27, 2020 11:06 AM
To: [redacted]
Cc: [redacted]
Subject: FW: Recertification for WP&S Personnel 2020
Please, advise.

From: [redacted]
Sent: Tuesday, October 27, 2020 11:06 AM
To: [redacted]
Cc: [redacted]
[redacted]
Subject: RE: Recertification for WP&S Personnel 2020
[redacted]
I did remind Sam of his job requirements and being an essential employee. He still doesn't want to attend the class in a closed room. I am planning to bring this issue in today's ATU/VTA meeting.
Regards,
[redacted]

From: [redacted]
Sent: Tuesday, October 27, 2020 10:15 AM
To: [redacted]
Cc: [redacted]
[redacted]
Subject: RE: Recertification for WP&S Personnel 2020
[redacted]
Please address this issue, you may want to remind Sam of the requirements of the position and being an Essential Employee.
[redacted]

From: [redacted]
Sent: Tuesday, October 27, 2020 10:03 AM
To: [redacted]
Cc: [redacted]
[redacted]
Subject: RE: Recertification for WP&S Personnel 2020
[redacted]
Sam has refused to attend the recert class tomorrow, unless it is outdoor.
Regards,
[redacted]

From: [redacted]
Sent: Friday, October 23, 2020 8:50 AM
To: [redacted]
Cc: [redacted]
Subject: RE: Recertification for WP&S Personnel 2020

[redacted]
Please, let me know the day you have the least students. Sam might not agree to attend the class with other employees for covid reasons.
Thanks.

From: [redacted]
Sent: Friday, October 23, 2020 8:38 AM
To: [redacted]
Subject: RE: Recertification for WP&S Personnel 2020
Thank you

From: [redacted]
Sent: Friday, October 23, 2020 8:33 AM
To: [redacted]
Cc: [redacted]
Subject: RE: Recertification for WP&S Personnel 2020
Hi [redacted]
Day Shift:
Tuesday:

1. [redacted]
2. [redacted]

Wednesday:

1. [redacted]
2. Sam Cassidy

Thanks,
[redacted]

From: [redacted]
Sent: Friday, October 23, 2020 8:04 AM
To: [redacted]
Cc: [redacted]
Subject: FW: Recertification for WP&S Personnel 2020
Good morning,
Next week I have scheduled recert for your staff. You were advised on August 26, 2020.
Please let me know what days your staff will be attending along with their names.
Thank you.
Regards,
[redacted]
95 W Younger Avenue, Building I
San Jose, CA 95110
[redacted]
<image001.png>

From: Lop[redacted]
Sent: Wednesday, August 26, 2020 10:38 AM
To: [redacted]

[redacted]

Cc: [redacted]

Subject: Recertification for WP&S Personnel 2020

August 26, 2020

Good morning,

Recertification classes will begin Tuesday, September 29th, 2020. Classes will be limited to five students per class. The recertification calendar is attached. Please respond with the dates your staff will be attending along with their name and badge. I will send out notifications as classes fill up. Let me know if you have any questions. Lastly, please advise your staff to report to our new location at 95 West Younger Avenue, Building I, and to comply with the covid-19 precautions including, but not limited to, wearing a face mask and the social distancing protocols. The Light Rail Operating Rulebook, Driver's License, and Medical Card are required for recertification class.

Thank you,

[redacted]

95 W Younger Avenue, Building I
San Jose, CA 95110

[redacted]

<image001.png>

From: [redacted]
To: [redacted]
Cc: [redacted]
Subject: Re: Recertification for WP&S Personnel 2020
Date: Monday, January 25, 2021 1:04:10 PM

Hi [redacted]

Please, have the room sanitized before the class. Also get a confirmation email from facility foreman or the Supervisor.

Thanks,
[redacted]

Sent from my iPhone

> On Jan 25, 2021, at 1:00 PM, [redacted] wrote:
>
> [redacted]
>
> Let's move forward with the recertification for the crew to report in Building H. [redacted] can recertify three persons, certified, i think we should move on that. [redacted] will be back to normal hours Friday. We can coordinate this remote training then. [redacted] is currently working 10:30pm - 6:30am, we appreciate your patience.
>
> [redacted] we will not need to block a classroom for this training, just waiting for [redacted] to identify a date that he is able to accommodate Sam's/[redacted] request.
>
> ---
>
> **From:** [redacted]
> **Sent:** Monday, January 25, 2021 11:21 AM
> **To:** [redacted]
> **Cc:** [redacted]
> **Subject:** FW: Recertification for WP&S Personnel 2020
> Hi [redacted]
> Sam has refused to take any indoor classes due to Covid reasons. [redacted] had agreed to bring laptops in building B. Please, let me know if it is possible.
> Thanks,
> [redacted]
>
> ---
>
> **From:** [redacted]
> **Sent:** Wednesday, October 28, 2020 5:18 PM
> **To:** [redacted]

Cc: [redacted]
Subject: Re: Recertification for WP&S Personnel 2020
Hi [redacted]
My apologies for not getting back to you. Let me discuss with my. Is and I will get back to you.
[redacted]

Sent from my iPhone

> On Oct 27, 2020, at 12:04 PM, [redacted] wrote:
>
> Hi [redacted]
> Please, advise.
> Regards,
> [redacted]
>
> **From:** [redacted]
> **Sent:** Tuesday, October 27, 2020 11:06 AM
> **To:** [redacted]
> **Cc:** [redacted]
> **Subject:** FW: Recertification for WP&S Personnel 2020
> Please, advise.
>
> **From:** [redacted]
> **Sent:** Tuesday, October 27, 2020 11:06 AM
> **To:** [redacted]
> **Cc:** [redacted]
> [redacted]
> **Subject:** RE: Recertification for WP&S Personnel 2020
> [redacted]
> I did remind Sam of his job requirements and being an essential employee. He still doesn't want to attend the class in a closed room. I am planning to bring this issue in today's ATU/VTA meeting.
> Regards,
> [redacted]
>
> **From:** [redacted]
> **Sent:** Tuesday, October 27, 2020 10:15 AM
> **To:** [redacted]
> **Cc:** [redacted]
> [redacted]
> **Subject:** RE: Recertification for WP&S Personnel 2020
> [redacted]
> Please address this issue, you may want to remind Sam of the requirements of the position and being an Essential Employee.

[redacted]

From: [redacted]
Sent: Tuesday, October 27, 2020 10:03 AM
To: [redacted]
Cc: [redacted]
Subject: RE: Recertification for WP&S Personnel 2020

[redacted]

Sam has refused to attend the recert class tomorrow, unless it is outdoor.
Regards,

[redacted]

From: [redacted]
Sent: Friday, October 23, 2020 8:50 AM
To: [redacted]
Cc: [redacted]
Subject: RE: Recertification for WP&S Personnel 2020

[redacted]

Please, let me know the day you have the least students. Sam might not agree to attend the class with other employees for covid reasons.
Thanks.

From: [redacted]
Sent: Friday, October 23, 2020 8:38 AM
To: [redacted]
Subject: RE: Recertification for WP&S Personnel 2020
Thank you

From: [redacted]
Sent: Friday, October 23, 2020 8:33 AM
To: [redacted]
Cc: [redacted]
Subject: RE: Recertification for WP&S Personnel 2020
Hi [redacted]
Day Shift:
Tuesday:

1. [redacted]
2. [redacted]

Wednesday:

1. [redacted]
2. Sam Cassidy

Thanks,

[redacted]

From: [redacted]
Sent: Friday, October 23, 2020 8:04 AM
To: [redacted]
Cc: [redacted]

Subject: FW: Recertification for WP&S Personnel 2020

Good morning,

Next week I have scheduled recert for your staff. You were advised on August 26, 2020. Please let me know what days your staff will be attending along with their names. Thank you.

Regards,

[redacted]

95 W Younger Avenue, Building I
San Jose, CA 95110
[redacted]

From: [redacted]

Sent: Wednesday, August 26, 2020 10:38 AM

To: [redacted]

Cc: [redacted]

Subject: Recertification for WP&S Personnel 2020

August 26, 2020

Good morning,

Recertification classes will begin Tuesday, September 29th, 2020.

Classes will be limited to five students per class. The recertification calendar is attached. Please respond with the dates your staff will be attending along with their name and badge. I will send out notifications as classes fill up. Let me know if you have any questions.

Lastly, please advise your staff to report to our new location at 95 West Younger Avenue, Building I, and to comply with the covid-19 precautions including, but not limited to, wearing a face mask and the social distancing protocols. The Light Rail Operating Rulebook, Driver's License, and Medical Card are required for recertification class.

Thank you,

[redacted]

95 W Younger Avenue, Building I
San Jose, CA 95110
[redacted]

SANTA CLARA
Valley Transportation Authority

January 31, 2014

Samuel Cassidy, #10391
1178 Angmar Ct.
San Jose, CA 95121

Dear Samuel Cassidy, #10391

On behalf of [redacted] this letter formalizes the oral offer made to you for a Change of Classification to the position of Substation Maintainer. The terms and conditions of your employment are as follows:

- Effective date will be: February 10, 2014
- Your hourly salary will be: $44.84
- Report to Division
  Guadalupe

Upon review and agreement of the above items, please sign the original offer letter and return it to my attention in the enclosed envelope. A copy of this offer letter is enclosed for your records.

Sincerely,

[redacted]

I accept the terms and conditions of this employment offer:

[signature] #10391
Samuel Cassidy, #10391

2/1/14
Date

Cc: [redacted]

TRANSACTION INFORMATION SHEET

NAME Samuel Cassidy COST CENTER 52225

EFFECTIVE DATE OF ACTION 2/10/2014 EMPLOYEE ID# 10391

WDN 9700

POSITION CODE 3460 POSITION TITLE Substation Maintainer

NEW HIRE: ☐ REGULAR ☐ RE-HIRE ☐ EXTRA HELP

UNION: ☐ AFSCME ☐ ATU ☐ NON-REP ☐ SEIU 521 ☐ TAEA

Date of Hire _____ Hourly / Biweekly _____ Grade _____ Step _____ Shift _____

The following new hire forms are attached if checked:

☐ W4 and DE-4 ☐ Authorization to Withhold Union Dues ☐ Direct Deposit

☐ Other:

☐ **SEPARATION** ☐ **RETIREMENT**

UNION: ☐ AFSCME ☐ ATU ☐ SEIU 521 ☐ TAEA ☐ NON-REP

The following separation forms are attached: ***COPY OF SEPARATION REPORT***

MISCELLANEOUS TRANSACTIONS

☐ Promotion ☐ Demotion ☐ Cost Center Change ☑ Change of Class promo.

☐ WDN Change ☐ Return to Former Class ☐ Re-Classification ☐ Transfer

☐ Others ☐ Position # Change

Present CC: 52210 Position 3397 Grade U65 Step 3 Shift _____

NEW CC: 52225 Position 3460 Grade U75 Step 3 Shift Code GD05

SALARY: Hourly 46.30 Bi-Weekly _____ Monthly _____

☐ Union Change from _____ to _____

Comments:

Processed By CW **Date** 2/10/2014 **Verified By** RN **Date** 2/10/14

HRA's Initials HRA's Initials

Original: ☐ Payroll

Copies: ☐ Retirement ☐ Personnel File

Last saved by: STEES, CAROLINE

rev. 09/28/12

SANTA CLARA
Valley Transportation Authority

Position [illegible]460
Work Sc[illegible]ule: GD05

BC

APPOINTMENT FORM

Name: Mr. / Ms. (Circle one) Cassidy (Last) Jr/Sr Samuel (First) MI Known As

Address: 1178 Angmar Court
San Jose, Ca 95121

Home Phone: 408-629-6522
Work Phone:
Phone/Ext:

Hiring Authority: [redacted]
Department: Operations
Work Unit: Way Power Signal
Cost Center: 52225
Department Personnel Administrator: [redacted]
Ext: 7098
Timekeeper: [redacted]
Ext: 7607
Work Location: Guadelupe
Shift: Days
Day Off: F/S
WDN#: 9700
Position Title: Substation Maintainer
Employee #: 10391

Requested Salary: ~~44.84~~ 46.30 Step: U75/3 Requested Effective Date: 02/10/14

- **HR must approve Appointment before offer is extended; HR will determine salaries for transfer or promotion.**
- Offers above the minimum salary range require detailed justification **signed by Division Director.**
- Certification List, Selection Interview Report, and Eligible List Evaluation Report must be attached.
- Extra Help appointments payrolled through VTA, require a detailed justification memo and an Application for Employment. (Note: Extra Help PERS retirees may work only 960 hours in a calendar year. All other Extra Help employees may work only 999 hours in a fiscal year.)
- If current VTA employee:
  Previous Position: Electronic mechanic Prev. Dept.: LR maint Prev. Work Loc.: Guadalupe

SIGNATURES (Required):

1. _____ Department Head Date
2. [redacted] 30JAN14 Division Chief/Deputy Director Date
3. [redacted] 1/30/14 Recruiting HR Analyst Date
4. [redacted] 1/30/14 Senior HR Analyst Date
5. [redacted] 1/30/14 Employee Services Manager Date
6. _____ Chief Administrative Officer Date
   (Offers- above step 3 or the midpoint)
7. _____ General Manager Date
   (Rehire of VTA Retiree receiving pension benefits)

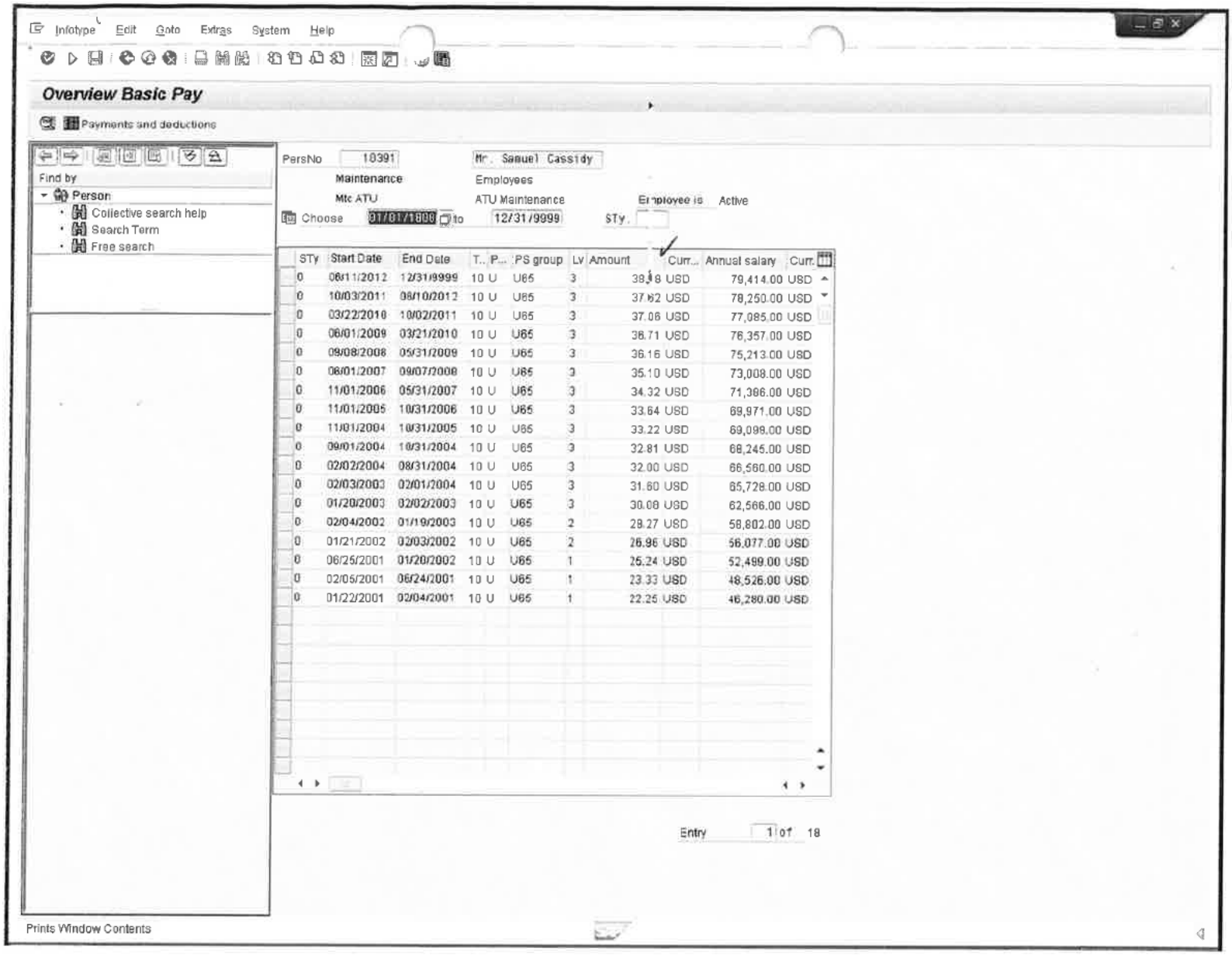
TYPE OF APPOINTMENT: (Employee Services Use Only)

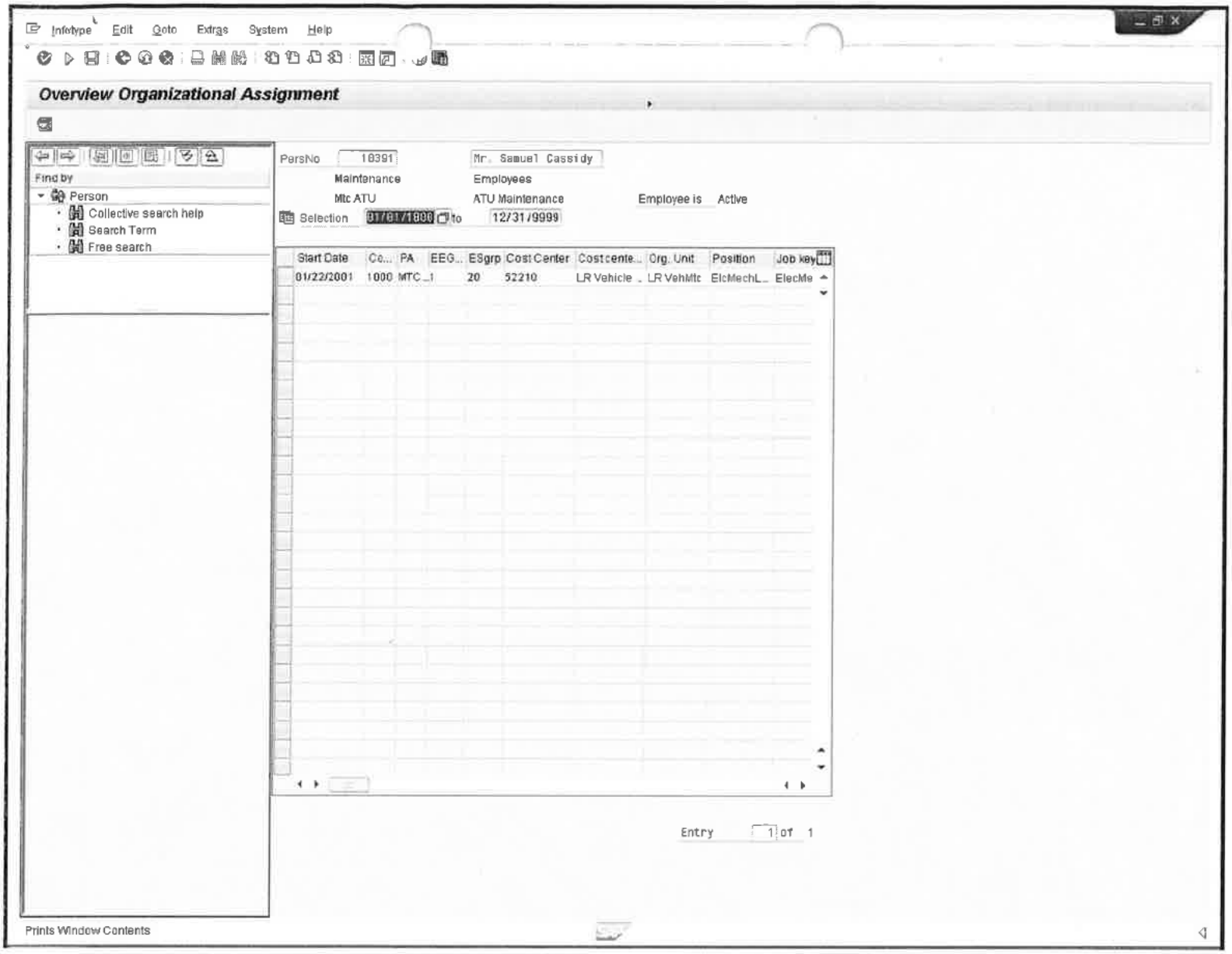
- ☐ New Hire
- ☒ ATU COC
- ☒ Transfer
- ☐ Provisional
- ☐ Recall (from layoff list)
- ☐ Extra Help
- ☐ Within Section
- ☒ Promotion
- ☐ PV to Regular
- ☐ Rehire (different job class/anytime)
- ☐ Intern
- ☐ Out of Section
- ☐ Demotion
- ☐ RFC/Callback
- ☐ Reinstatement (same job class/within 1 yr)
- ☐ Unclassified
- ☐ Return to Former Class (must have held permanent status)
- ☐ Reinstatement (per Settlement Agreement)

Offer: Accepted / Rejected *Analyst's Signature & Date:* [redacted] 1/30/14

- ☒ **Safety Sensitive**
- ☒ **Driver Record Pull**
- ☒ **VTA Retiree**
- ☐ **At Will**
- ☐ **ATU to Non-ATU**

Benefits Class: ATU Bargaining Unit: ATU Date: 1/30/14
Processing PSA: Date:


Infotype Edit Goto Extras System Help
Overview Basic Pay
Payments and deductions
Find by
Person
Collective search help
Search Term
Free search
PersNo 10391
Mr. Samuel Cassidy
Maintenance
Employees
Mtc ATU
ATU Maintenance
Employee is Active
Choose 01/01/1800 to 12/31/9999 STy.
STy Start Date End Date T.. P... PS group Lv Amount Curr... Annual salary Curr.
0 06/11/2012 12/31/9999 10 U U65 3 38.18 USD 79,414.00 USD
0 10/03/2011 06/10/2012 10 U U65 3 37.62 USD 78,250.00 USD
0 03/22/2010 10/02/2011 10 U U65 3 37.06 USD 77,085.00 USD
0 06/01/2009 03/21/2010 10 U U65 3 36.71 USD 76,357.00 USD
0 09/08/2008 05/31/2009 10 U U65 3 36.16 USD 75,213.00 USD
0 06/01/2007 09/07/2008 10 U U65 3 35.10 USD 73,008.00 USD
0 11/01/2006 05/31/2007 10 U U65 3 34.32 USD 71,386.00 USD
0 11/01/2005 10/31/2006 10 U U65 3 33.64 USD 69,971.00 USD
0 11/01/2004 10/31/2005 10 U U65 3 33.22 USD 69,099.00 USD
0 09/01/2004 10/31/2004 10 U U65 3 32.81 USD 68,245.00 USD
0 02/02/2004 08/31/2004 10 U U65 3 32.00 USD 66,560.00 USD
0 02/03/2003 02/01/2004 10 U U65 3 31.60 USD 65,728.00 USD
0 01/20/2003 02/02/2003 10 U U65 3 30.08 USD 62,566.00 USD
0 02/04/2002 01/19/2003 10 U U65 2 28.27 USD 58,802.00 USD
0 01/21/2002 02/03/2002 10 U U65 2 26.96 USD 56,077.00 USD
0 06/25/2001 01/20/2002 10 U U65 1 25.24 USD 52,499.00 USD
0 02/05/2001 06/24/2001 10 U U65 1 23.33 USD 48,526.00 USD
0 01/22/2001 02/04/2001 10 U U65 1 22.25 USD 46,280.00 USD
Entry 1 of 18
Prints Window Contents


Infotype
Edit
Goto
Extras
System
Help
Overview Organizational Assignment
Find by
Person
Collective search help
Search Term
Free search
PersNo 10391
Mr. Samuel Cassidy
Maintenance
Employees
Mtc ATU
ATU Maintenance
Employee is Active
Selection 01/01/1800 to 12/31/9999
Start Date
Co...
PA
EEG...
ESgrp
Cost Center
Costcente...
Org. Unit
Position
Job key
01/22/2001
1000
MTC_1
20
52210
LR Vehicle ...
LR VehMtc
ElcMechL...
ElecMe
Entry 1 of 1
Prints Window Contents

U Table Effective
06-11-12

Range	Class	Step 1	Step 2	Step 3	Step 4	Step 5	Step 6	Step 7	Step 8	Step 9
U70	Foreperson - LRT	36.61	39.12	41.62						
	Overhaul & Repair Foreperson									
	Paint & Body Foreperson									
	Paint & Body Foreperson - LRT									
	Transit Foreperson									
	Upholstery Foreperson									
U75	Overhead Line Worker	39.46	42.15	44.84						
	Substation Maintainer									
U77	Light Rail Power Foreperson	42.57	45.47	48.37						

Top step+.35 (reg progession)

INFORMATION SUBJECT TO CHANGE.
DATA ACCURATE AS OF THE DATE LISTED.

Santa Clara Valley Transportation Authority
Classification and Salary Listing eff. 11-07-13

Mid Point of Broad Range = to Step 5 of Step Range

FLSA	EEO	Rep	Benef	Salary	VTA#	Class		Base Annual Rate			Base Monthly Rate			Bi-weekly Rate			Hourly Rate of Pay		
Stat	Code	Unit	Class	Range	Job #	Code	Class Title	Min	Mid/Top Step	Max	Min	Mid/Top Step	Max	Min	Mid/Top Step	Max	Min	Mid/Top Step	Max
E	2	TAEA	ENAR	G325	1288	L45	Sr Mechanical Engr-Auto Systems	98,621.12	119,863.38		8,218.43	9,988.62		3,793.12	4,610.13		47.41	57.63	
E	2	SEIU	SEIU	B564	3080	T8K	Sr Network Analyst	87,627.28	106,226.12		7,302.27	8,852.18		3,370.28	4,085.62		42.13	51.07	
E	1A	NOREP	ACAD	R26	5225	T0U	Sr Policy Analyst	95,843.26	111,178.34	126,513.14	7,986.94	9,264.86	10,542.76	3,686.28	4,276.09	4,865.89	46.08	53.45	60.82
E	2	SEIU	SEIU	B564	5006	U1K	Sr Programmer	87,627.28	106,226.12		7,302.27	8,852.18		3,370.28	4,085.62		42.13	51.07	
E	2	AFSCME	AFSCME	A458	1290	C72	Sr Real Estate Agent	93,856.10	114,115.82		7,821.34	9,509.65		3,609.85	4,389.07		45.12	54.86	
E	2	AFSCME	AFSCME	A458	5075	C72	Sr Real Estate Agent (U)	93,856.10	114,115.82		7,821.34	9,509.65		3,609.85	4,389.07		45.12	54.86	
N	6	SEIU	SEIU	B557	3730	T9H	Sr Signal Maintainer	84,788.86	102,742.12		7,065.74	8,561.84		3,261.11	3,951.62		40.76	49.40	
E	2	SEIU	SEIU	B564	3081	T8L	Sr Systems Administrator	87,627.28	106,226.12		7,302.27	8,852.18		3,370.28	4,085.62		42.13	51.07	
E	2	TAEA	ENAR	G325	1291	T4F	Sr Systems Design Engineer	98,621.12	119,863.38		8,218.43	9,988.62		3,793.12	4,610.13		47.41	57.63	
E	2	TAEA	ENAR	G325	1292	L01	Sr Systems Engineer	98,621.12	119,863.38		8,218.43	9,988.62		3,793.12	4,610.13		47.41	57.63	
N	6	ATU	ATU	U65	1293	LST	Sr Track Worker	69,888.00	79,414.40		5,824.00	6,617.87		2,688.00	3,054.40		33.60	38.18	
E	2	TAEA	ENAR	G325	1294	L30	Sr Transportation Engineer	98,621.12	119,863.38		8,218.43	9,988.62		3,793.12	4,610.13		47.41	57.63	
E	2	AFSCME	AFSCME	A458	1296	T66	Sr Transportation Planner	93,856.10	114,115.82		7,821.34	9,509.65		3,609.85	4,389.07		45.12	54.86	
E	2	AFSCME	AFSCME	A458	1297	T49	Sr Transportation Planner (U)	93,856.10	114,115.82		7,821.34	9,509.65		3,609.85	4,389.07		45.12	54.86	
E	2	AFSCME	AFSCME	A458	3555	T7V	Sr Transportation Planner- Model/Analysis	93,856.10	114,115.82		7,821.34	9,509.65		3,609.85	4,389.07		45.12	54.86	
E	2	AFSCME	AFSCME	A458	1298	T65	Sr Transportation Plnr-Prgmg & Grants	93,856.10	114,115.82		7,821.34	9,509.65		3,609.85	4,389.07		45.12	54.86	
E	2	SEIU	SEIU	B564	3905	T0U	Sr Web Developer	87,627.28	106,226.12		7,302.27	8,852.18		3,370.28	4,085.62		42.13	51.07	
N	5	SEIU	SEIU	B439	1299	G81	Storekeeper	48,407.06	58,493.24		4,033.92	4,874.44		1,861.81	2,249.74		23.27	28.12	
N	6	ATU	ATU	U75	1300	LSM	Substation Maintainer	82,076.80	93,267.20		6,839.73	7,772.27		3,156.80	3,587.20		39.46	44.84	
E	2	AFSCME	AFSCME	A448	1302	T2Q	Supervising Maintenance Instructor	89,379.42	108,667.26		7,448.29	9,055.61		3,437.67	4,179.51		42.97	52.24	
E	2	AFSCME	AFSCME	A448	4032	T0I	Supervising Maintenance Instructor - LRT	89,379.42	108,667.26		7,448.29	9,055.61		3,437.67	4,179.51		42.97	52.24	
N	6	ATU	ATU	U50	1305	SPM	Support Mechanic	46,030.40	65,769.60		3,835.87	5,480.80		1,770.40	2,529.60		22.13	31.62	
E	1A	AFSCME	AFSCME	A478	1306	T97	Survey & Mapping Manager	103,496.76	125,805.84		8,624.98	10,483.83		3,980.76	4,838.69		49.76	60.48	
E	1A	NOREP	ACMG	R31	1580	T6C	SVRT Project Controls Manager	122,345.86	141,921.26	161,496.40	10,195.49	11,826.77	13,458.03	4,705.61	5,458.51	6,211.40	58.82	68.23	77.64
E	2	SEIU	SEIU	B492	5001	U1L	Systems Administrator I	62,173.64	75,236.98		5,181.13	6,269.75		2,391.29	2,893.73		29.89	36.17	
E	2	SEIU	SEIU	B532	3480	T9A	Systems Administrator II	75,236.98	91,082.94		6,269.75	7,590.25		2,893.73	3,503.19		36.17	43.79	
E	1A	AFSCME	AFSCME	A488	1307	T4A	Systems Design Manager	108,667.26	132,098.98		9,055.61	11,008.25		4,179.51	5,080.73		52.24	63.51	
E	2	SEIU	SEIU	B564	1289	G07	Technical Project Manager	87,627.28	106,226.12		7,302.27	8,852.18		3,370.28	4,085.62		42.13	51.07	
E	2	AFSCME	AFSCME	A428	1308	B66	Technical Trainer	81,065.66	98,562.62		6,755.47	8,213.55		3,117.91	3,790.87		38.97	47.39	
E	2	AFSCME	AFSCME	A448	1309	T82	Technical Training Supervisor	89,379.42	108,667.26		7,448.29	9,055.61		3,437.67	4,179.51		42.97	52.24	
E	2	AFSCME	AFSCME	A468	3630	T9E	Technology Infrastructure Supervisor	98,562.62	119,820.48		8,213.55	9,985.04		3,790.87	4,608.48		47.39	57.61	
E	1A	NOREP	ACMG	R31	1187	T80	Technology Manager	122,345.86	141,921.26	161,496.40	10,195.49	11,826.77	13,458.03	4,705.61	5,458.51	6,211.40	58.82	68.23	77.64
N	6	ATU	ATU	U65	1310	LTW	Track Worker	60,112.00	68,307.20		5,009.33	5,692.27		2,312.00	2,627.20		28.90	32.84	
N	6	SEIU	SEIU	B426	2655	T7T	Transit Center Maintenance Worker	45,541.34	55,008.98		3,795.11	4,584.08		1,751.59	2,115.73		21.89	26.45	
E	7	AFSCME	AFSCME	A428	1375	T4J	Transit Division Supervisor	81,065.66	98,562.62		6,755.47	8,213.55		3,117.91	3,790.87		38.97	47.39	
N	6	ATU	ATU	U70	1316	MFM	Transit Foreperson	78,148.80	86,569.60		6,345.73	7,214.13		2,928.80	3,329.60		36.61	41.62	
E	8	AFSCME	AFSCME	A448	1317	MD1	Transit Maintenance Supervisor	89,379.42	108,667.26		7,448.29	9,055.61		3,437.67	4,179.51		42.97	52.24	
N	6	ATU	ATU	U65	1318	TRM	Transit Mechanic	69,888.00	79,414.40		5,824.00	6,617.87		2,688.00	3,054.40		33.60	38.18	
N	6	ATU	ATU	U55	1319	TMG	Transit Mechanic - G	60,112.00	68,307.20		5,009.33	5,692.27		2,312.00	2,627.20		28.90	32.84	
N	6	ATU	ATU	U67	2980	TMH	Transit Mechanic - Hydrogen	73,340.80	83,345.60		6,111.73	6,945.47		2,820.80	3,205.60		35.26	40.07	
N	5	ATU	ATU	U60	1320	SYM	Transit Radio Dispatcher	49,712.00	71,011.20		4,142.67	5,917.60		1,912.00	2,731.20		23.90	34.14	
E	2	AFSCME	AFSCME	A428	1322	B6Q	Transit Safety Officer	81,065.66	98,562.62		6,755.47	8,213.55		3,117.91	3,790.87		38.97	47.39	
E	2	AFSCME	AFSCME	A428	4030	T0G	Transit Service Development Supervisor	81,065.66	98,562.62		6,755.47	8,213.55		3,117.91	3,790.87		38.97	47.39	
N	5	SEIU	SEIU	B438	1324	C88	Transit Svc Development Aide	48,182.42	59,183.84		4,015.20	4,848.65		1,853.17	2,237.84		23.16	27.97	

IF THERE IS A DISCREPANCY BETWEEN THIS LISTING AND THE DATA IN SAP, THE DATA IN SAP WILL BE CONSIDERED CORRECT.

Form W-4 (2009)

Purpose. Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay. Consider completing a new Form W-4 each year and when your personal or financial situation changes.

Exemption from withholding. If you are exempt, complete **only** lines 1, 2, 3, 4, and 7, and sign the form to validate it. Your exemption for 2009 expires February 16, 2010. See Pub. 505, Tax Withholding and Estimated Tax.

Note. You cannot claim exemption from withholding if (a) your income exceeds $950 and includes more than $300 of unearned income (for example, interest and dividends) and (b) another person can claim you as a dependent on their tax return.

Basic instructions. If you are not exempt, complete the **Personal Allowances Worksheet** below. The worksheets on page 2 further adjust your withholding allowances based on itemized deductions, certain credits, adjustments to income, or two-earner/multiple job situations.

Complete all worksheets that apply. However, you may claim fewer (or zero) allowances. For regular wages, withholding must be based on allowances you claimed and may not be a flat amount or percentage of wages.

Head of household. Generally, you may claim head of household filing status on your tax return only if you are unmarried and pay more than 50% of the costs of keeping up a home for yourself and your dependent(s) or other qualifying individuals. See Pub. 501, Exemptions, Standard Deduction, and Filing Information, for information.

Tax credits. You can take projected tax credits into account in figuring your allowable number of withholding allowances. Credits for child or dependent care expenses and the child tax credit may be claimed using the **Personal Allowances Worksheet** below. See Pub. 919, How Do I Adjust My Tax Withholding, for information on converting your other credits into withholding allowances.

Nonwage income. If you have a large amount of nonwage income, such as interest or dividends, consider making estimated tax payments using Form 1040-ES, Estimated Tax for Individuals. Otherwise, you may owe additional tax. If you have pension or annuity income, see Pub. 919 to find out if you should adjust your withholding on Form W-4 or W-4P.

Two earners or multiple jobs. If you have a working spouse or more than one job, figure the total number of allowances you are entitled to claim on all jobs using worksheets from only one Form W-4. Your withholding usually will be most accurate when all allowances are claimed on the Form W-4 for the highest paying job and zero allowances are claimed on the others. See Pub. 919 for details.

Nonresident alien. If you are a nonresident alien, see the Instructions for Form 8233 before completing this Form W-4.

Check your withholding. After your Form W-4 takes effect, use Pub. 919 to see how the amount you are having withheld compares to your projected total tax for 2009. See Pub. 919, especially if your earnings exceed $130,000 (Single) or $180,000 (Married).

Personal Allowances Worksheet (Keep for your records.)

A Enter "1" for **yourself** if no one else can claim you as a dependent . . . . . A ____

B Enter "1" if:
- You are single and have only one job; or
- You are married, have only one job, and your spouse does not work; or
- Your wages from a second job or your spouse's wages (or the total of both) are $1,500 or less. . . B ____

C Enter "1" for your **spouse.** But, you may choose to enter "-0-" if you are married and have either a working spouse or more than one job. (Entering "-0-" may help you avoid having too little tax withheld.) . . . . . C ____

D Enter number of **dependents** (other than your spouse or yourself) you will claim on your tax return . . . . . D ____

E Enter "1" if you will file as **head of household** on your tax return (see conditions under **Head of household** above) . E ____

F Enter "1" if you have at least $1,800 of **child or dependent care expenses** for which you plan to claim a credit . . F ____
(**Note.** Do **not** include child support payments. See Pub. 503, Child and Dependent Care Expenses, for details.)

G **Child Tax Credit** (including additional child tax credit). See Pub. 972, Child Tax Credit, for more information.
- If your total income will be less than $61,000 ($90,000 if married), enter "2" for each eligible child; then **less** "1" if you have three or more eligible children.
- If your total income will be between $61,000 and $84,000 ($90,000 and $119,000 if married), enter "1" for each eligible child plus "1" **additional** if you have six or more eligible children. G ____

H Add lines A through G and enter total here. (**Note.** This may be different from the number of exemptions you claim on your tax return.) ▶ H ____

For accuracy, **complete all worksheets that apply.**
- If you plan to **itemize or claim adjustments to income** and want to reduce your withholding, see the **Deductions and Adjustments Worksheet** on page 2.
- If you have **more than one job** or are **married and you and your spouse both work** and the combined earnings from all jobs exceed $40,000 ($25,000 if married), see the **Two-Earners/Multiple Jobs Worksheet** on page 2 to avoid having too little tax withheld.
- If **neither** of the above situations applies, **stop here** and enter the number from line H on line 5 of Form W-4 below.

---------- **Cut here and give Form W-4 to your employer. Keep the top part for your records.** ----------

Form **W-4**
Department of the Treasury
Internal Revenue Service

Employee's Withholding Allowance Certificate

▶ **Whether you are entitled to claim a certain number of allowances or exemption from withholding is subject to review by the IRS. Your employer may be required to send a copy of this form to the IRS.**

OMB No. 1545-0074

2009

1 Type or print your first name and middle initial.	Last name	2 Your social security number
Samuel J.	Cassidy	[redacted]
Home address (number and street or rural route)	3 ☒ Single ☐ Married ☐ Married, but withhold at higher Single rate. Note. If married, but legally separated, or spouse is a nonresident alien, check the "Single" box.	
1178 Angmar Court		
City or town, state, and ZIP code	4 If your last name differs from that shown on your social security card, check here. You must call 1-800-772-1213 for a replacement card. ▶ ☐	
San Jose CA 95121		

5	Total number of allowances you are claiming (from line H above **or** from the applicable worksheet on page 2)	5 5
6	Additional amount, if any, you want withheld from each paycheck	6 $
7	I claim exemption from withholding for 2009, and I certify that I meet **both** of the following conditions for exemption. • Last year I had a right to a refund of **all** federal income tax withheld because I had **no** tax liability **and** • This year I expect a refund of **all** federal income tax withheld because I expect to have **no** tax liability. If you meet both conditions, write "Exempt" here . . . ▶	7

Under penalties of perjury, I declare that I have examined this certificate and to the best of my knowledge and belief, it is true, correct, and complete.

Employee's signature (Form is not valid unless you sign it.) ▶ Samuel Cassidy **Date** ▶ 2/25/2010

8 Employer's name and address (Employer: Complete lines 8 and 10 only if sending to the IRS.)	9 Office code (optional)	10 Employer identification number (EIN)

SANTA CLARA
Valley Transportation Authority

December 30, 2005

TO WHOM IT MAY CONCERN:

Subject: EMPLOYMENT VERIFICATION

This is to certify that Samuel Cassidy is currently employed with the Santa Clara Valley Transportation Authority as an Electro-Mechanic. He has been employed since January 22, 2001. His hourly salary is $33.64.

If you have any questions or need further information please contact our Employee Services office at (408) 321-5582.

Sincerely yours,

[redacted]

[redacted]
Personnel Services Administrator

SANTA CLARA
Valley Transportation Authority

VTA PERSONNEL
05 DEC 27 PM 2:10

December 27, 2005

Samuel Cassidy, Badge # 10391
1178 Angmar Ct.
San Jose, CA 95121

Dear Samuel Cassidy:

On 11/16/05 you booked off Industrial Injury and you have not returned to work. During this absence you have not maintained regular contact with Guadalupe supervision as required by VTA's Absence Management Program Procedure. Therefore, please be advised that the Procedure states that employees who have been absent due to an illness or industrial injury are responsible for:

> **"Providing regular updates to their immediate supervisor or designee on a biweekly basis when out on a leave for 14 or more consecutive calendar days. Failure to report as required will be recorded and may be cause for discipline."**

Since you have not contacted Guadalupe supervision since 11/16/05, you are being sent this letter, reminding you to contact us once every two weeks. Be advised that failure to maintain regular contact with Guadalupe supervision once every two weeks could subject you to progressive disciplinary actions, up to and including termination. You are to contact [redacted] immediately.

Sincerely,

[redacted]

Guadalupe
Equipment Superintendent Light Rail

c: Division File
Office of Employee Relations
Employee Services – Employee File
Operations Administration – Absence Program Manager
Collective Bargaining Unit (Proof of Service for ATU)

Revised 11/04

ATU - ACT

SANTA CLARA
Valley Transportation Authority

PAYROLL DEPOSIT AUTHORIZATION (NET PAY)

Employee ID #	Employee Name	Employee SS #	Contact Phone #
	Sam Cassidy	[redacted]	

I hereby authorize the Santa Clara Valley Transportation Authority to process the payroll direct deposit as designated to the institution(s) below. This authorization is to remain in full force and effect until I revoke it in writing in such time and such manner to afford the Transportation Authority and the institution(s) reasonable opportunity to act on it (up to 2 pay periods), or upon termination of my employment from the Santa Clara Valley Transportation Authority.

Signature Sam Cass Date 1/31/2001

NEW [X] CHANGE [ ] CANCEL [ ]

CHECKING [X] OR SAVINGS [ ]

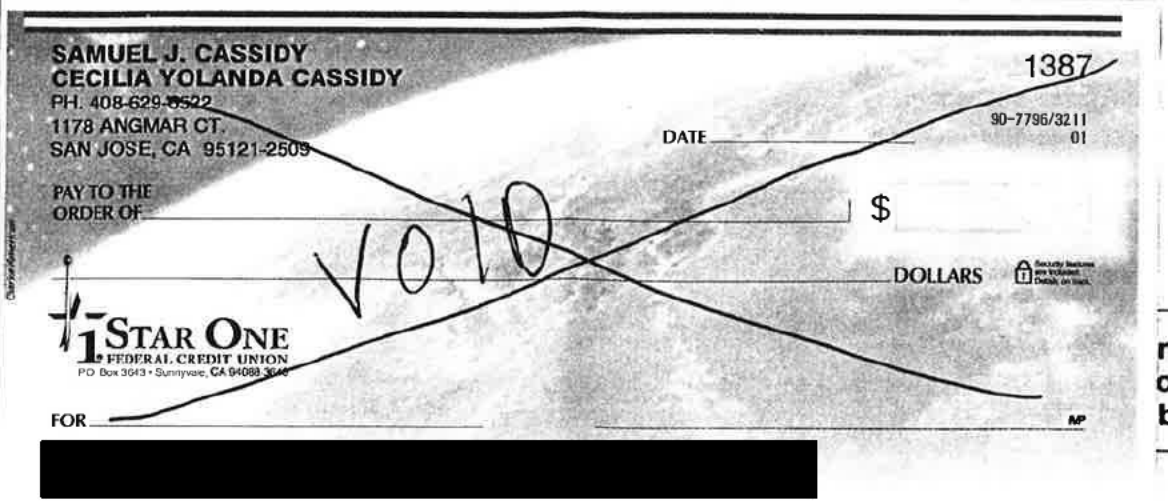
If you have checked new or change please attach a **voided check** to this authorization and complete the bank information below.

Bank Name (include Branch name) Star One Federal Credit Union

Bank City: Sunnyvale State: CA

ABA Routing Number: Account Number: [redacted]

PLEASE ATTACH VOIDED CHECK BELOW



riods for processing ounts.. becomes active.

08/00

TRANSACTION INFORMATION SHEET

NAME Samuel J. Cassidy INDEX SJ210

SOCIAL SEC # [redacted] EMPLOYEE ID# 10391

EFFECTIVE DATE OF ACTION 1-22-01 BUDGET UNIT — WDN 1700

POSITION CODE 3397 POSITION TITLE Electro Mech.

NEW HIRE: ☒ Coded ☐ Extra Help

UNION: ☐ 715 ☒ ATU ☐ CEMA ☐ ENAR ☐ Non-Rep Other: _____

Mgr. ID — Payroll Group ATU Benefit Class ATU

Date of Hire 1-22-01 Salary Hrly 22.35 Grade U65 Step I Shift G002

The following new hire forms are attached if checked:

☒ W4 and DE-4 ☒ Authorization to Withhold Union Dues ☐ Direct Deposit

☐ Other:

☐ SEPARATION ☐ RETIREMENT

UNION: ☐ 715 ☐ ATU ☐ CEMA ☐ ENAR ☐ Non-Rep Other: _____

The following separation forms are attached:

MISCELLANEOUS TRANSACTIONS

☐ Demotion ☐ FMLA ☐ IC Chg ☐ Leave of Absence ☐ Maternity

☐ Medical ☐ Promo ☐ Return From Leave ☐ RFC ☐ Transfer

☐ WC ☐ Other _____

Present IC: _____ Position _____ Grade _____ Step _____ Payroll Group _____

NEW IC: _____ Position _____ Grade _____ Step _____ Payroll Group _____

Mgr ID _____ Benefit Class _____ Salary Hrly _____ Shift _____ Shift Code _____

☐ Union Change from _____ to _____

Comments:

Processed By AP Date 1-23-01 Verified By JV Date 1/26/01

PSA's Initials PSA's Initials

DISTRIBUTION

original: FINANCE

copies (check all that apply):

	date forwarded:		date forwarded:
☐ ATU Benefits Enrollment	_____	☐ COBRA Enrollment	_____
☐ Non-ATU Benefits Enrollment	_____	☐ Retirement Desk	_____
☐ Benefits Audit	_____	☐ Personnel File w/attachments	_____
☐ Benefits Billing	_____		

SANTA CLARA
Valley Transportation Authority

Position No. 3397

6009 OK dh

APPOINTMENT FORM

Name: Mr. Ms. (Circle one) Cassidy (Last) Jr/Sr Samuel (First) MI Known As

Address: 1178 Angmar Court
San Jose, CA 95121

Home Phone: 629-6522
Work Phone:

Hiring Authority: [redacted]
Phone/Ext: [redacted]

Department: Rail Maintenance
Work Unit: ML05
Cost Center: 52210

Department Personnel Administrator: [redacted]
Ext: [redacted]

Timekeeper: [redacted]
Ext: [redacted]

Work Location: Guadalupe
Shift:
Day Off:
WDN#: 1700

Position Title: Electro Mechanic
Bargaining Unit: ATU

(Do not complete for Bid. If an employee, Transfer and Promotional rules determine salary. Personnel will complete.)

SALARY: $22.25
STEP: 1

DATE OFFER EXTENDED & ACCEPTED (AFTER APPROVAL BY HR):
DATE OFFER EXTENDED & REJECTED (AFTER APPROVAL BY HR):

TYPE OF APPOINTMENT:
Appointment Effective Date: ~~1/14/01~~ 1/22/01

(Please attach the Application for Employment, unless the position is filled through certification.)

- [X] Regular
- [ ] Extra Help
- [ ] Regular PV
- [ ] Substitute PV
- [ ] Probationary PV
- [ ] Transfer
- [ ] Promotion
- [ ] Demotion
- [ ] Unclassified
- [ ] Bid (no signatures required)
- [ ] Reinstatement
- [ ] Change of Class

FOR PAYROLL, EXTRA HELP EMPLOYEES, a detailed justification memo must be attached, along with a completed Application for Employment. Extra Help PERS retirees may work only 960 hours in a calendar year. All other Extra Help employees, may work only 999 hours in a fiscal year.

If the appointee is presently a VTA employee, please provide the following information:

Previous Position: Prev. Dept.: Prev. Work Loc:

SIGNATURES (Required):

1. [redacted] 1/8/2001
Department Head Date

2. [redacted] 1/8/2001
Division Director Date

3. [redacted] 01/09/01
Recruiting HR Analyst Date

4. [redacted] 1/9/01
Senior HR Analyst Date

5. [redacted] 1/9/01
Personnel Manager Date

6.
Human Resources Director Date
(only if offer is above step 3 or the midpoint)

For vacancies filled through transfer or certification, the 'Certification Document' and the 'Authority Action Plan Memo' must be attached.

FOR PERSONNEL USE ONLY: PSA: Date:

[redacted] 1/4/01

SANTA CLARA
Valley Transportation Authority

~~January 3, 2001~~

(REVISION OF ORIGINAL OFFER LETTER, RE: SERVICE MECHANIC, DATED 1-3-2001).

Samuel Cassidy
1178 Angmar Court
San Jose, CA 95121

Start Date: Monday, ~~01/22/01~~
Start Time: 9:00 AM

Dear Mr. Cassidy:

On behalf of [redacted] this letter formalizes the verbal offer made to you for the position of ~~Service Mechanic~~. The terms and conditions of your employment are as follows:

- Your starting salary is ~~$13.07~~/hour.
- Your employment is contingent upon completing a pre-employment physical, including a urine drug screen and a criminal investigation (fingerprint check), **prior to your start date**. Please see the attached "New Hire Instructions" for specific information.

Upon review and agreement of the above items, please sign the original offer letter and return it to my attention in the enclosed envelope. A copy of this offer letter is enclosed for your records.

We are looking forward to you joining our team at VTA.

Sincerely,

[redacted]
Human Resources Manager

I accept the terms and conditions of this employment offer:

Samuel Cassidy _____ Date _____

Enclosures
Files
Cc: [redacted]

[redacted]

From: [redacted]
Sent: Wednesday, January 10, 2001 7:13 AM
To: [redacted]
Cc:

Subject: FW: Electro-Mechanics

[redacted]

The following candidates for Electro Mechanic have accepted job offers:

	Start Date	
Samuel Cassidy	**1/22/01**	Originally scheduled to start as a Service Mechanic on 1/22/01. Personnel needs to cancel the Service Mechanic appointment and process as an Electro Mechanic.

[redacted]

We are still waiting for a response from [redacted] declined job offer. He has already accepted position of Senior Utility Worker and will start on 1/15/01.

Please call if you have any questions. Thank you.

-----Original Message-----
From: [redacted]
Sent: Wednesday, January 10, 2001 6:56 AM
To: [redacted]
Cc:
Subject: RE: Electro-Mechanics

[redacted], I will continue to try to contact [redacted] today

[redacted]

-----Original Message-----
From: [redacted]
Sent: Tuesday, January 09, 2001 9:47 AM
To: [redacted]
Cc:
Subject: Electro-Mechanics

[redacted]

You can offer each of the following individuals the position of Electro-Mechanic with a start date of 01/29/01. The pay rate will be step 1, 22.25 an hour.

[redacted] ....left message, waiting for a response

Samuel Cassidy 629-6522 .....Accepted offer 1/9/01 via phone...(Can start 1/22/01)

[redacted] ....Accepted offer 1/9/01 via phone

[redacted] ....Declined offer1/9/01 via phone (has accepted Utility Worker with VTA)

[redacted] ....Accepted offer 1/9/01 via phone

Please let me know as each accepts so that I am able to send out offer letters.

[redacted]

Hi [redacted]
We are waiting on accepts for these 5 people - [redacted] knows to contact you.
We have discussed with [redacted] and a few of the start dates may be sooner since a couple of the guys already started the hire process. - Thanks!
[redacted]

[redacted]

From: [redacted]
Sent: Tuesday, January 09, 2001 [illegible] AM
To: [redacted]
Cc:
Subject: Electro-Mechanics

Hi [redacted]

You can offer each of the following individuals the position of Electro-Mechanic with a start date of 01/29/01. The pay rate will be step 1, 22.25 an hour.

[redacted]

Samuel Cassidy 629-6522

[redacted]

Please let me know as each accepts so that I am able to send out offer letters.

[redacted]

3331 North First Street · San Jose, CA 95134-1906 · Administration 408.321.5555 · Customer Service 408.321.2300

SANTA CLARA
Valley Transportation Authority

**(REVISION OF ORIGINAL OFFER LETTER
RE: SERICE MECHANIC, DATED 01/03/2001)**

January 11, 2001

Samuel Cassidy
1178 Angmar Court
San Jose, CA 95121

Start Date: Monday, 01/22/2001
Start Time: 9:00 AM

Dear Mr. Cassidy:

On behalf of [redacted] this letter formalizes the verbal offer made to you for the position of Electro Mechanic. The terms and conditions of your employment are as follows:

- Your starting salary is $22.25/hourly.
- Your employment is contingent upon completing a pre-employment physical, including a urine drug screen and a criminal investigation (fingerprint check), **prior to your start date**. Please see the attached "New Hire Instructions" for specific information.

Upon review and agreement of the above items, please sign the original offer letter and return it to my attention in the enclosed envelope. A copy of this offer letter is enclosed for your records.

We are looking forward to you joining our team at VTA.

Sincerely,

[redacted]

Human Resources Manager

I accept the terms and conditions of this employment offer:

Samuel Cassidy _____ Date _____

Enclosures
Files
Cc: [redacted]

SANTA CLARA
Valley Transportation Authority

NEW HIRE INSTRUCTIONS

Your employment is contingent upon completing a pre-employment physical (including a urine drug screen) and a criminal investigation (fingerprint check) prior to your start date.

1. Please call [redacted] to set up your physical appointment. Your physical **must** be completed and a clearance received **before** your start date.

2. Please read the enclosed instructions for setting up your fingerprint appointment. Fingerprinting **must** be completed **before** your start date.

3. You **must** sign and return the enclosed physical and fingerprint waiver forms to the Personnel Department **before** your start date.

4. Please read the benefits overview and list of documents enclosed. This information will be reviewed and completed on your start date.

5. Please report to the **Personnel Department** at 3331 North First Street, San Jose, CA 95134, at **9:00 AM on your start date** for your new hire orientation.

6. When you report to the Personnel Department, **please bring with you the unsigned copy of the Physical and Fingerprint Verification form** to be signed in the presence of a Personnel Department employee.

Please call [redacted] in Personnel Services if you have any questions.

SANTA CLARA
Valley Transportation Authority

EMPLOYMENT APPLICATION

VTA PERSONNEL

READ INSTRUCTIONS CAREFULLY BEFORE COMPLETING

- Answer all questions. Print in ink or type. Incomplete or illegible applications may be disqualified.
- A separate application must be submitted for each position.
- Falsification or deceptive omission of requested information will cause application rejection, removal from eligible lists, or dismissal from employment.
- Machine copied applications will not be accepted.
- For additional information or questions contact the **Personnel Department** at **(408) 321-5575.**
- Unless otherwise stated on examination bulletin, return your completed, signed, and dated application to:

Valley Transportation Authority
Personnel Department
3331 North First Street, Building B
San Jose, CA 95134-1906

1. Position (Give exact title of position for which you are applying): Electro Mechanic — ☒ Full-time ☐ Part-time ☐ Transfer ☐ W.O.O.C.

2. Your Last Name: Cassidy — First: Samuel — Middle: James — 3. Social Security Number: [redacted]

4. Your Street Address: 1178 Angmar Ct. — City: San Jose — State: CA — Zip: 95121

5. Home Phone: (408) 629-6522 — Business Phone: (408) 448-2277 — 6. Driver's license number, State, type & expiration date–if required for this position: (N9804334) (CA) (class 3 $4) Exp 8/03

7. Have you ever applied for any position with VTA? If so, when and what position?
7a. ☐ Yes ☒ No — Any prior name? If so, what?
7b. ☐ Yes ☒ No

8. Have you ever been employed with VTA? If so, please explain.
☐ Yes ☒ No

9. Do you have any relatives working for VTA? If so, please provide name and relationship.
☐ Yes ☒ No

10. Have you received any vehicle citations for moving violations within the last 3 years?
☐ Yes ☒ No

11. Have you ever been convicted by a court for **ANY** felony or misdemeanor?
(Not all convictions are an automatic bar to employment. Each case is considered on its individual merits.) ☐ Yes ☒ No

ALL CONVICTIONS, WHETHER FELONY OR MISDEMEANOR MUST BE DISCLOSED.
Failure to disclose any conviction shall disqualify an applicant from employment and future employment consideration with VTA.

12. Do you speak any languages other than English? Please list.

Any **YES** answers to items 7a, 7b, 8, 9, 10, or 11 must be **FULLY** explained here. Attach a separate sheet if necessary.

13. Do you need any accommodation in taking an examination due to a disability? ☐ Yes ☒ No
13a. If yes, please describe the desired accommodation: _____

14. Have you ever been granted an accommodation for a previous examination at VTA? ☐ Yes ☒ No
You must provide the Personnel Department with written verification from a doctor, rehabilitation counselor, or other authorized person confirming your disability and indicating a reasonable accommodation.

This space for Personnel use only

Application: ☒ Accepted ☐ Rejected — Reviewer's Initials: [illegible] — Date Reviewed: 10/27/00

Reason for Rejection:
☐ Experience
☐ Education
☐ Req. Driver's License
☐ DUI
☐ Late Application
☐ Incomplete Application
☐ Criminal Conviction
☐ Need More Information
☐ Other (specify) _____

Reviewer's comments:

LIST CODE:	LEM-00
SEQUENCE:	03
DMV SENT:	
DMV CLEAR:	
F.P. DATE:	
F.P. CLEAR:	

AN EQUAL OPPORTUNITY EMPLOYER

15. Education

Did you graduate from high school? ☐ Yes ☒ No

If you did not graduate from high school, do you have a G.E.D. equivalent? ☒ Yes ☐ No

Name and Location of Trade school or College attended	Major Subject	Units Completed	Degree Received
De Anza College	Auto Tech	160+	AA degree

16. Licenses and Certificates which are applicable to this position:

Description Smog license Issued by ASE & BAR Number #1-8 (plus L1)

- All 8 ASE Licenses (incl L1 advanced engine performance)

17. Employment History

- You must list **at least** the last **ten** years of work experience, unless total work history is less than 10 years.
- Resumes will not be accepted in place of a completed application.
- Complete all questions and respond to all requirements listed in the job bulletin.
- Describe different positions held with the same employer in different blocks.
- **List your most recent experience first & attach additional sheets if necessary.**
- List relevant volunteer experience.

From: Mo./Yr. To: Mo./Yr.	Employer (Business or Agency Name)	Title of Your Present or Previous Position	Telephone Number
6/92 → Present	Almaden Mazda	Journeyman Mechanic	[redacted]
Hours Per Wk. 40+	Address City State Zip	Name of Supervisor: [redacted] May we contact this employer? ☐ Yes ☒ No	
Salary: $ 23.38/hr.	Duties: Repair & service of cars and trucks,		
Reason for Leaving: Currently employed here.	including: Electrical, driveability, transmission, engines, alignments, suspension and brakes.		

From: Mo./Yr. To: Mo./Yr.	Employer (Business or Agency Name)	Title of Your Previous Position	Telephone Number
5/90 → 6/92	Stevens Creek Acura	Journeyman Mechanic	[redacted]
Hours Per Wk. 40+	Address 4747 Stevens Creek Blvd. City Santa Clara State Zip	Name of Supervisor: [redacted] May we contact this employer? ☒ Yes ☐ No	
Salary: $ 19.00/hr	Duties: Repair & service of cars, including:		
Reason for Leaving: Laid off due to lack of work.	electrical diagnosis & repair.		

From: Mo./Yr. To: Mo./Yr.	Employer (Business or Agency Name)	Title of Your Previous Position	Telephone Number
11/89 → 6/90	Sar/Pruneridge Unical 76	Mechanic / Mgr.	
Hours Per Wk. 40+	Address Saratoga Ave, City Santa Clara State CA Zip	Name of Supervisor: [redacted] May we contact this employer? ☒ Yes ☐ No	
Salary: $ 17.46	Duties: General repair and service of cars &		
Reason for Leaving: Wanted to get back into dealership.	trucks including: electrical and smog checks.		

From: Mo./Yr. To: Mo./Yr.	Employer (Busines… gency Name)	Title of Yo… vious Position	Telephone Number
9/85 11/89	Wes Behel Pontiac	Journeyman Mechanic	

Hours Per Wk.	Address / City / State / Zip	Name of Supervisor:
40+	Stevens Creek Blvd. Santa Clara $	[redacted]

May we contact this employer? ☒ Yes ☐ No

Salary: $ 18^{65}/hr

Duties: All forms of auto repair & Service (excluding body work), but including Some Diesel, and alot of electrical.

Reason for Leaving: Union went on Strike

From: Mo./Yr. To: Mo./Yr. | Employer (Business or Agency Name) | Title of Your Previous Position | Telephone Number

Hours Per Wk. | Address | City | State | Zip | Name of Supervisor:

May we contact this employer? ☐ Yes ☐ No

Salary: $ | Duties:

Reason for Leaving:

From: Mo./Yr. To: Mo./Yr. | Employer (Business or Agency Name) | Title of Your Previous Position | Telephone Number

Hours Per Wk. | Address | City | State | Zip | Name of Supervisor:

May we contact this employer? ☐ Yes ☐ No

Salary: $ | Duties:

Reason for Leaving:

From: Mo./Yr. To: Mo./Yr. | Employer (Business or Agency Name) | Title of Your Previous Position | Telephone Number

Hours Per Wk. | Address | City | State | Zip | Name of Supervisor:

May we contact this employer? ☐ Yes ☐ No

Salary: $ | Duties:

Reason for Leaving:

Certification: I certify that all of the statements made on this application are true, complete and correct to the best of my knowledge and belief and are made in good faith. I understand that I will be fingerprinted and investigated prior to appointment.

Signature of Applicant (sign in ink)	Date Signed
[illegible]	10/21/2000

EMPLOYMENT DISQUALIFICATION DUE TO CRIMINAL CONVICTIONS

(This form must be completed)

Valley Transportation Authority passed a resolution which requires the disqualification of applicants who have been convicted of certain types of criminal misconduct. Information regarding this policy and the types of offenses which disqualify applicants is provided on the job application form. This policy requires all applicants for employment to disclose all criminal convictions on the application form. All applicants for employment will be fingerprinted for the purpose of obtaining "Criminal Conviction" information.

Because it is not always possible for the Personnel staff to make a determination as to whether conviction information disclosed on a job application would result in mandatory job disqualification, applicants may be accepted into the examination process (up to and including final interview and job offer) and may be employed pending the results of the fingerprint check.

The fact that a conviction has been disclosed on the application and that a candidate has nonetheless been accepted into the examination process does not mean that a determination has been made by the Personnel Department regarding the conviction. Such determination cannot be made until the results of the fingerprint check are received.

Because the results of the fingerprint check take several weeks to be received, it is often the case that an offer of employment is made before the results of the fingerprint check have been received. If the results of the fingerprint check disclose a disqualifying offense or a discrepancy between the conviction information provided on the application and the fingerprint check, the employee will be subject to immediate termination.

I have read and understood the information regarding the Valley Transportation Authority procedures regarding mandatory disqualification of job applicants.

Sam Cassidy
Applicant Name (Print)

Sam Cass
Applicant Signature

10/21/2000
Date Signed

Electro Mechanic
Position

EMPLOYMENT QUALIFICATION INFORMATION SHEET

Important Information— Please Read Thoroughly

VTA must verify the identity and employment authorization of all new employees to comply with the 1986 Immigration Reform and Control Act. This verification is required only after an offer of employment has been made. For further information regarding the required verification, please contact the Personnel Department at (408) 321-5575.

- YOUR DRIVING RECORD WILL BE VERIFIED. Most of VTA's positions require a valid California driver's license and a good driving record. You may obtain a copy of your record at the nearest Department of Motor Vehicles office. ANY omissions regarding moving violations received within three (3) years prior to the date of application will be automatic disqualification.
- You will be required to complete a pre-employment physical examination, including drug screen.
- In accordance with Federal requirements, all persons appointed to safety-sensitive positions are subject to drug/alcohol testing in the following situations: pre-employment (including promotion/demotion or reinstatement); unannounced random; post accident; reasonable suspicion; return to duty (inclusive of follow up testing).
- Proof of diplomas, licenses/certifications, etc., must be provided prior to appointment.

MANDATORY DISQUALIFICATION OF JOB APPLICANT

As a condition of employment you will be fingerprinted for the purpose of obtaining "Criminal Conviction" information from California and Federal record agencies. Each applicant shall disclose on the application form ALL criminal convictions. Failure to disclose ALL convictions shall disqualify an applicant from employment and future employment consideration with VTA. Applicants will be disqualified from employment for criminal misconduct if they have been convicted of or have forfeited bond or collateral upon a charge of a disqualifying public offense listed as follows:

- Operating a motor vehicle while under the influence of alcohol, an amphetamine, a narcotic drug, a formulation of an amphetamine, or a derivative of a narcotic drug.
- A crime involving the transportation, possession, sale or possession for sale, or unlawful use of amphetamines, narcotic drugs,formulations of an amphetamine, or derivatives of narcotic drugs.
- A felony or misdemeanor involving moral turpitude.
- A felony or serious misdemeanor involving violence.
- Leaving the scene of a traffic accident which resulted in personal injury or death.
- A felony involving the use of a motor vehicle.

Applicants will be disqualified from employment with VTA for conduct resulting in the following:

- Any person determined to be a mentally disordered sex offender under the provision of Article I (commencing with Section 6300), Chapter 2, Part 2, Division 6 of the Welfare and Institution Code or under similar provisions of law of any other state.
- Any person required to register as a sex offender under the provisions of Section 290 of the Penal Code or under similar provisions of law of any other state.

IMPERSONATION OF APPLICANT IN COMPETITIVE EXAMINATIONS AND OTHER CONDUCT

Any person who impersonates another person or permits or aids in any manner any other person to impersonate him/her in connection with any examination or application; furnishes or obtains examination questions or other examination material prepared and intended for use in any examination before such examination; or uses any unfair means to cause or attempt to cause any applicant on an eligible list to waive any rights, may be guilty of a misdemeanor and punishable as such.

QUESTIONS REGARDING EXAMINATION PROCESSES

Questions regarding the fairness or appropriateness of examination processes should be submitted in writing to the Personnel Manager within (5) working days of taking the test.

FOR APPLICANTS WHO DO NOT PASS AN EXAMINATION

Provided the examination is given on a continuous basis, applicants who do not pass an examination may reapply 45 days after the initial examination. If the applicant does not pass the second time, the applicant may reapply after another 90 days has elapsed. If the applicant does not pass a third time within a six month period, the applicant may not reapply for another six months.

FINGERPRINT PROGRAM NOTIFICATION FORM

Dear VTA Job Applicant:

As a condition of employment, you will be fingerprinted to obtain Criminal Conviction information from California and Federal record agencies.

A resolution passed on behalf of the Santa Clara Valley Transportation Authority on February 24, 1989, states that an applicant will not be considered for employment who is in one of the following two categories:

A. Convicted upon a charge of a disqualifying public offense listed below:

- Operating a motor vehicle while under the influence of alcohol, an amphetamine, a narcotic drug, formulations of anamphetamine, or a derivative of a narcotic drug.
- A crime involving the transportation, possession, sale or possession for sale, or unlawful use of amphetamines, narcotic drugs, formulations of an amphetamine, or derivatives of narcotic drugs.
- A felony or misdemeanor involving moral turpitude.
- A felony or serious misdemeanor involving violence.
- Leaving the scene of a traffic accident which resulted in personal injury or death.
- A felony involving the use of a motor vehicle.

B. Conduct resulting in the following:

- Any person determined to be a mentally disordered sex offender under the provisions of Article I (commencing with Section 6300), Chapter 2, Part 2, Division 6 of the Welfare and Institutions Code or under similar provisions of law of any other state.
- Any person required to register as a sex offender under the provisions of Section 290 of the Penal Code or under similar provisions of law of any other state.

Information Form To Obtain Criminal Conviction Information*

Please fill out the following information. (Print or Type)

1. Position Title: Electro Mechanic
2. Name: Cassidy (Last) Samuel (First) James (Middle)
3. Other names you have used:
   Name: _____ (Last) _____ (First) _____ (Middle)
4. Sex: [X] Male [ ] Female
5. Height: 6 Feet 1 Inches
6. Weight: 205 lbs
7. Eye Color: Blue
8. Hair Color: Blonde
9. Date of Birth: 8 (Month) 29 (Day) 63 (Year)
10. Place of Birth: CA (State)
11. Driver's License Number: N9804334
12. Social Security Number: [redacted]

I have read and understand the foregoing Fingerprint Program Notification Form and certify that the information provided herein is correct.

Signature: _____ (Applicant's Legal Signature) Date: 10/21/2000

* All applicants for employment with VTA shall be fingerprinted. Criminal history information will be obtained to verify the information disclosed on the application.

– To Be Completed by Bus Driver Applicants Only –

In compliance with Assembly Bill 4045, I am responding to the following inquiry:

In the past two (2) years, **I HAVE** [ ] **I HAVE NOT** [ ] taken a driving test for employment as a bus driver with **any** transit property.

Signature: _____ Date: _____

EQUAL EMPLOYMENT OPPORTUNITY QUESTIONNAIRE

Do Not Detach (Please Print or Type)

POSITION TITLE (Write in complete title) Electro-mechanic

VTA is required by the Federal Government to provide statistical information about applicants and employees to demonstrate that we meet equal employment opportunity requirements. This information will be treated confidentially and will be used for statistical reporting purposes only. The form will be kept in a confidential file separate from the application for employment.

ETHNIC ORIGIN

- ☐ **AMERICAN INDIAN OR ALASKAN NATIVE** Persons descended from the original people of North America and who maintain cultural identification through tribal affiliation or community recognition.
- ☐ **AFRICAN AMERICAN/BLACK (not of Hispanic origin)** All persons having origins in any of the Black racial groups of Africa.
- ☐ **ASIAN OR PACIFIC ISLANDER** All persons having origins in any of the original peoples of the Far East, Southeast Asia, the Indian Subcontinent, or the Pacific Islands. This area includes, for example, China, Japan, Korea, the Philippine Islands, and Samoa.
- ☐ **HISPANIC/LATINO** Includes all persons of Mexican, Puerto Rican, Cuban, Central or South American, or other Spanish culture or origin, regardless of race.
- ☒ **WHITE (Caucasian)**

SEX

☒ Male ☐ Female

AGE GROUP

☐ Under 21 ☐ 21-29 ☒ 30-39 ☐ 40-49 ☐ 50-59 ☐ 60 or Over

RECRUITMENT RESEARCH (Please indicate below how you became aware of this job opportunity)

- ☒ Newspaper (Name) S.J. Mercury
- ☐ Spanish Newspaper _____
- ☐ Vietnamese Newspaper _____
- ☐ Job Fair (Where) _____
- ☐ Other _____

_____

- ☐ Community Organization
- ☐ Trade or Professional Journal
- ☐ Employee
- ☐ Internet
- ☐ Radio
- ☐ Exam Notification Card
- ☐ Announcement Posting
- ☐ Friend
- ☐ Television
- ☐ Telephone Recording

DISABILITY

☐ Disability ☒ No Disability

If you are disabled, the Personnel Department will make efforts to provide reasonable accommodations in the examination process. If you have special needs, please notify the **Personnel Department** by calling **(408) 321-5575.**

THIS INFORMATION IS FOR STATISTICAL PURPOSES ONLY AND WILL NOT HAVE ANY EFFECT UPON YOUR APPLICATION.

October 27, 2000

Samuel Cassidy
1178 Angmar Ct
San Jose, CA 95121

Dear Candidate,

Thank you for attending the VTA Great Job Fair! I have reviewed your application for the position of Electro-Mechanic. Your application has been accepted, and you will be notified by mail of the next step in the testing process.

If there is a change in your name, address, or phone number, please contact the Personnel Office at [redacted].

Thank you for your interest in employment with VTA.

Sincerely,

[redacted]
Human Resources Analyst

SANTA CLARA
Valley Transportation Authority

TRANSPORTATION
AGENCY OF
PERSONNEL SERVICE
JAN 10 2 12 PM '01

(REVISION OF ORIGINAL OFFER LETTER
RE: SERICE MECHANIC, DATED 01/03/2001)

January 11, 2001

Samuel Cassidy
1178 Angmar Court
San Jose, CA 95121

Start Date: Monday, 01/22/2001
Start Time: 9:00 AM

Dear Mr. Cassidy:

On behalf of [redacted], this letter formalizes the verbal offer made to you for the position of Electro Mechanic. The terms and conditions of your employment are as follows:

- Your starting salary is $22.25/hourly.
- Your employment is contingent upon completing a pre-employment physical, including a urine drug screen and a criminal investigation (fingerprint check), **prior to your start date**. Please see the attached "New Hire Instructions" for specific information.

Upon review and agreement of the above items, please sign the original offer letter and return it to my attention in the enclosed envelope. A copy of this offer letter is enclosed for your records.

We are looking forward to you joining our team at VTA.

Sincerely,

[redacted]
Human Resources Manager

I accept the terms and conditions of this employment offer:

Samuel Cassidy — 1/13/01
Samuel Cassidy — Date

Enclosures
Files
Cc: [redacted]
Processing Unit
[redacted]

[redacted]

TRANSPORTATION
SUPPORT
OFFICE
JAN 16 3 00 PM '01

MEDICAL EXAMINER RECOMMENDATIONS

Applicant/Employee Sam Cassidy

Position Title: Bus Driver

Company: Valley Transportation

Based on the information provided to me by the employer concerning the tasks of the position offered and based on my medical findings, it is my opinion that the aforementioned individual

[X] is capable of performing the required tasks inherent to the work position that has been offered to him/her.

[ ] is capable of performing the required tasks inherent to the work position that has been offered to him/her, except for the following: *

Does not include UDS Results

[ ] should be placed on medical hold pending:

PHYSICIAN: Name: [redacted]

Signature: [redacted]

Date: Jan 15 01

---

* in compliance with the Americans with Disabilities Act, the medical examiner may **not** list on this form either medical diagnoses or conditions. Only restrictions and/or tasks that cannot be adequately performed by the applicant/employee are to be listed.

MEDICAL EXAMINER'S CERTIFICATE

I certify that I have examined the driver named below in accordance with the Motor Carrier Safety Regulations (49 CFR 391. 41-391.49) and with knowledge of his or her duties, I find him or her qualified under the regulations. A completed examination form for this person is on file in my office.

Qualified only when wearing: ☒ Corrective lenses. ☐ A hearing aid.

☐ Qualified by operation of 49 CFR 391.64 (special exemption for drivers who were in 1992-1996 federal vision/diabetes pilot study).

☐ Medically unqualified unless accompanied by a _____

☐ Medically unqualified unless driving within an exempt intracity zone.

DRIVER LICENSE NO.
N9804334

DRIVER'S NAME (Print)
Sam Cassidy

(FOLD HERE)

DRIVER [redacted] S. CA 95121

MEDICAL [redacted] M D.

MEDICAL EXAMINER'S PHONE NO.
408 [redacted]

MEDICAL EXAMINER'S LICENSE/CERTIFICATION NO.
[redacted]

STATE ISSUED
CA

MEDICAL EXAMINER'S SIGNATURE
X [redacted]

DL 51A (REV. [redacted])

PHYSICIAN, CHIROPRACTOR, PHYSICIAN'S ASSISTANT, OR ADVANCED PRACTICE NURSE COMPLETES THIS SECTION

Check each item in appropriate box to show "Qualified" or "Not Qualified." See instructions for condition or defects that must be noted. Explain any special findings or test results **NOT** in an acceptable tolerance range. Use additional sheets, if needed.

Driver License Number N980 4334 Name Sam Cassidy Date of Exam 1-12-01

COLORED BOXES MUST BE COMPLETED	QUALIFIED	NOT QUALIFIED	EXPLAIN ABNORMAL FINDINGS OR CONDITIONS
2. **General Appearance and Development.** Note marked overweight and any defects that could be caused by alcoholism, thyroid intoxication, or other illnesses.	✓		
3. **Visual Acuity:** Must be at least 20/40 in each eye with/without corrective lenses. UNCORRECTED: Both 20/25, Left 20/30, Right 20/50. CORRECTED: 20/20, 20/20, 20/20. CONTACTS? ☐ Yes ☐ No. Are the lenses well-adapted and tolerated? ☐ Yes ☐ No	✓		
4. **Peripheral Vision:** Left 90° Right 90° **Express in degrees.** (Must be at least 70°.)	✓		
5. **Color Vision:** Can distinguish red, amber, green as used in traffic signals.	✓		
6. **Pupillary Reflex.** Light Check both eyes.	✓		
7. **Accommodation:** Check both eyes.	✓		
8. **Eyes.** Note any evidence of disease or injury.	✓		
9. **Hearing:** can perceive forced whispered voice in the better ear at not less than five feet with or without hearing aid. Forced whisper heard in right ear 5 ft., left ear 5 ft. If audiometer used, hearing loss in decibels: Right ear: ____ at 500 Hz ____ 1,000 Hz ____ 2,000 Hz; Left ear: ____ at 500 Hz ____ 1,000 Hz ____ 2,000 Hz	✓		
10. **Ears.** Note any evidence of disease or injury.	✓		
11. **Romberg.** ☑ Normal ☐ Abnormal	✓		
12. **Lungs/chest**	✓		
13. **X-ray Results:** If indicated. Check qualified if x-rays not necessary.			
14. **Heart.** Stethoscope exam required. Note murmurs, arrhythmias, and any evidence of cardiovascular disease. Electrocardiogram results, if indicated: If organic disease is present, is it fully compensated? ☐ Yes ☐ No	✓		
15. **Blood Pressure:** If consistently above 160/90 mm. Hg., further tests may be necessary to determine if driver is qualified. (See instructions.) Systolic 132 Diastolic 86	✓		
16. **Pulse:** Before exercise 92. Immediately after 2 min. exercise 132.	✓		
17. **Abdomen.** Note any defects or injuries that could interfere with normal function. Note scars, abnormal masses, tenderness. Hernia ☐ Yes ☑ No If so, where? _____ Is truss worn? ☐ Yes ☐ No	✓		
18. **Gastrointestinal.** Ulceration or other disease. ☐ Yes ☑ No	✓		
19. **Genitourinary.** Note scars, urethal discharge. Urinalysis is required. Urine: Spec. Gr 1015 Alb Neg Sugar Neg	✓		
20. **Upper and lower extremities.** Record the loss or impairment of leg, foot, toe, arm, hand, or fingers.	✓		
21. **Spine:** Note any disease or injury.	✓		
22. **Knee jerk reflex:** Right: ✓ Normal ____ Increased ____ Absent; Left: ✓ Normal ____ Increased ____ Absent	✓		
23. **Results of any other laboratory tests.** Note any evidence of disease or injury indicated. (Attach extra sheets, if needed.)			
24. **Mental condition.** Note any condition requiring medication or therapy.	✓		

DMV
A Public Service Agency

DMV USE ONLY ☐ Updated by _____ O51

MEDICAL EXAMINATION REPORT

DRIVER COMPLETES THIS SECTION

DRIVER LICENSE NO.	CLASS APPLYING FOR	SOCIAL SECURITY NO.
N9804334	☐ Original Certification ☐ Renewal	[redacted]
BIRTH DATE (MO., DAY, YR.) MO 8 DAY 29 YR 63	**WORK TELEPHONE NO.** ( )	**HOME TELEPHONE NO** (408) 629-6522

NAME (FIRST, MIDDLE, LAST) Samuel James Cassidy

ADDRESS 1178 Angmar Ct. CITY San Jose STATE CA ZIP CODE 95121

HEALTH HISTORY (Please explain any "YES" answers)

	YES	NO
Head, neck, or spinal injury	☐	☒
Seizure, convulsions, or fainting	☐	☒
Dizziness or frequent headaches	☐	☒
Eye problem (except corrective lenses)	☐	☒
Cardiovascular (heart or blood vessel) disease	☐	☒
Lung disease (include TB and asthma)	☐	☒
Nervous stomach or ulcer	☐	☒
Diabetes	☐	☒
Kidney disease (including stones or blood in urine)	☐	☒
Muscular disease	☐	☒
Extensive confinement by illness or injury	☐	☒
Permanent defect	☐	☒
Psychiatric disorder	☐	☒
Any other nervous disorder	☐	☒
Problems with the use of alcohol or drugs	☐	☒
Syphilis or gonorrhea	☐	☒
Rheumatic fever	☐	☒
Suffering from any other disease	☐	☒
Any major illness last 5 years	☐	☒
Any operations last 5 years	☐	☒
Currently taking medicine	☒	☐

EXPLANATION: (Include onset date, diagnosis, medication, physician's name and address and any current condition or limitation. Attach additional sheet, if needed).

Taking Effexor for depression.

I certify under penalty of perjury under the laws of the State of California that the information I have provided is true and correct and is complete information concerning my health.

DRIVER'S SIGNATURE X [signature] DATE 1/12/01

PHYSICIAN, CHIROPRACTOR, PHYSICIAN'S ASSISTANT, OR ADVANCED PRACTICE NURSE COMPLETES THIS SECTION

DRIVER'S IDENTITY VERIFIED BY:

☐ California Driver License No.: N9804334 ☐ Other Photo ID (Specify ID used): _____

A completed examination form is on file in my office.

I certify under penalty of perjury under the laws of the State of California that I have examined the driver named above *in accordance with the Motor Carrier Safety Regulations (49 CFR 391.41—391.49) and with knowledge of the driving duties, I find this person is:*

☑ qualified UNTIL 1 / 12 / 03
(***Must insert date.*** *Usually, it is two years from exam date.)*

☐ qualified only when wearing: ☑ Corrective lenses ☐ Hearing aid

☐ medically unqualified unless accompanied by a _____ waiver.

☐ qualified by operation of 49 CFR §391.64

☐ medically unqualified unless driving within an exempt intracity zone.

☐ not qualified

SIGNATURE OF AUTHORIZED MEDICAL EXAMINER	DATE OF EXAM	LICENSE OR CERTIFICATE NO. (ISSUING STATE
X [redacted]	1-12-01	[redacted]

NAME (PRINT) [redacted]

1. PLACE DOCTOR'S OFFICE STAMP IN THIS SPACE

TITLE ☐ Chiropractor ☐ Advanced Practice Nurse ☑ Physician (☑ M.D. ☐ D.O.) ☐ Physician's Assistant

TELEPHONE NO. [redacted]

ADDRESS [redacted] CITY STATE ZIP CODE

DMV COMPLETES THIS SECTION

REVIEWED BY	DATE	FIELD OFFICE	APP. DATE

HEADQUARTER'S REVIEW

Form W-4 (2001)

Purpose. Complete Form W-4 so your employer can withhold the correct Federal income tax from your pay. Because your tax situation may change, you may want to refigure your withholding each year.

Exemption from withholding. If you are exempt, complete only lines 1, 2, 3, 4, and 7, and sign the form to validate it. Your exemption for 2001 expires February 18, 2002.

Note: *You cannot claim exemption from withholding if (1) your income exceeds $750 and includes more than $250 of unearned income (e.g., interest and dividends) and (2) another person can claim you as a dependent on their tax return.*

Basic instructions. If you are not exempt, complete the **Personal Allowances Worksheet** below. The worksheets on page 2 adjust your withholding allowances based on itemized deductions, certain credits, adjustments to income, or two-earner/two-job situations. Complete all worksheets that apply. They will help you figure the number of withholding allowances you are entitled to claim. **However, you may claim fewer (or zero) allowances.**

Head of household. Generally, you may claim head of household filing status on your tax return only if you are unmarried and pay more than 50% of the costs of keeping up a home for yourself and your dependent(s) or other qualifying individuals. See line E below.

Tax credits. You can take projected tax credits into account in figuring your allowable number of withholding allowances. Credits for child or dependent care expenses and the child tax credit may be claimed using the **Personal Allowances Worksheet** below. See **Pub. 919,** How Do I Adjust My Tax Withholding? for information on converting your other credits into withholding allowances.

Nonwage income. If you have a large amount of nonwage income, such as interest or dividends, consider making estimated tax payments using **Form 1040-ES,** Estimated Tax for Individuals. Otherwise, you may owe additional tax.

Two earners/two jobs. If you have a working spouse or more than one job, figure the total number of allowances you are entitled to claim on all jobs using worksheets from only one Form W-4. Your withholding usually will be most accurate when all allowances are claimed on the Form W-4 for the highest paying job and zero allowances are claimed on the others.

Check your withholding. After your Form W-4 takes effect, use Pub. 919 to see how the dollar amount you are having withheld compares to your projected total tax for 2001. Get Pub. 919 especially if you used the **Two-Earner/Two-Job Worksheet** on page 2 and your earnings exceed $150,000 (Single) or $200,000 (Married).

Recent name change? If your name on line 1 differs from that shown on your social security card, call 1-800-772-1213 for a new social security card.

Personal Allowances Worksheet (Keep for your records.)

A Enter "1" for **yourself** if no one else can claim you as a dependent . . . . . A ____

B Enter "1" if:
- You are single and have only one job; or
- You are married, have only one job, and your spouse does not work; or
- Your wages from a second job or your spouse's wages (or the total of both) are $1,000 or less. . . B ____

C Enter "1" for your **spouse.** But, you may choose to enter -0- if you are married and have either a working spouse or more than one job. (Entering -0- may help you avoid having too little tax withheld.) . . . . . C ____

D Enter number of **dependents** (other than your spouse or yourself) you will claim on your tax return . . . . . D ____

E Enter "1" if you will file as **head of household** on your tax return (see conditions under **Head of household** above) . E ____

F Enter "1" if you have at least $1,500 of **child or dependent care expenses** for which you plan to claim a credit . . F ____
(**Note:** *Do* ***not*** *include child support payments. See* ***Pub. 503,*** *Child and Dependent Care Expenses, for details.*)

G **Child Tax Credit** (including additional child tax credit):
- If your total income will be between $18,000 and $50,000 ($23,000 and $63,000 if married), enter "1" for each eligible child.
- If your total income will be between $50,000 and $80,000 ($63,000 and $115,000 if married), enter "1" if you have two eligible children, enter "2" if you have three or four eligible children, or enter "3" if you have five or more eligible children. G ____

H Add lines A through G and enter total here. (**Note:** *This may be different from the number of exemptions you claim on your tax return.*) ▶ H ____

For accuracy, complete all worksheets that apply.
- If you plan to **itemize or claim adjustments to income** and want to reduce your withholding, see the **Deductions and Adjustments Worksheet** on page 2.
- If you are **single,** have **more than one job** and your combined earnings from all jobs exceed $35,000, **or** if you are **married** and have a **working spouse or more than one job** and the combined earnings from all jobs exceed $60,000, see the **Two-Earner/Two-Job Worksheet** on page 2 to avoid having too little tax withheld.
- If **neither** of the above situations applies, **stop here** and enter the number from line H on line 5 of Form W-4 below.

Cut here and give Form W-4 to your employer. Keep the top part for your records.

Form **W-4**
Department of the Treasury
Internal Revenue Service

Employee's Withholding Allowance Certificate

▶ **For Privacy Act and Paperwork Reduction Act Notice, see page 2.**

OMB No. 1545-0010
2001

1 Type or print your first name and middle initial: Samuel J. | Last name: Cassidy | 2 Your social security number: [redacted]

Home address (number and street or rural route): 1178 Angmar Ct.

3 ☐ Single ☒ Married ☐ Married, but withhold at higher Single rate.
Note: *If married, but legally separated, or spouse is a nonresident alien, check the Single box.*

City or town, state, and ZIP code: San Jose CA 95121

4 **If your last name differs from that on your social security card, check here. You must call 1-800-772-1213 for a new card.** ▶ ☐

5 Total number of allowances you are claiming (from line **H** above **or** from the applicable worksheet on page 2) . . 5 1

6 Additional amount, if any, you want withheld from each paycheck . . . . . 6 $

7 I claim exemption from withholding for 2001, and I certify that I meet **both** of the following conditions for exemption:
- Last year I had a right to a refund of **all** Federal income tax withheld because I had **no** tax liability **and**
- This year I expect a refund of **all** Federal income tax withheld because I expect to have **no** tax liability.

If you meet both conditions, write "Exempt" here . . . . . ▶ 7

Under penalties of perjury, I certify that I am entitled to the number of withholding allowances claimed on this certificate, or I am entitled to claim exempt status.

Employee's signature (Form is not valid unless you sign it.) ▶ Samuel Cassidy Date ▶ 1-22-2001

8 Employer's name and address (Employer: Complete lines 8 and 10 only if sending to the IRS.)

9 Office code (optional)

10 Employer identification number

Employment Development Department

State of California

EMPLOYEE'S WITHHOLDING ALLOWANCE CERTIFICATE

DE 4

Type or Print Your Full Name: Samuel James Cassidy

Your Social Security Number: [redacted]

Home Address (Number and Street or Rural Route): 1178 Angmar Ct.

City, State and ZIP Code: San Jose CA 95121

Status Withholding Allowances:
- ☐ SINGLE or MARRIED (with two or more incomes
- ☐ MARRIED (one income)
- ☒ HEAD OF HOUSEHOLD

1. Number of allowances you are claiming for this job from the Regular Withholding Allowances Worksheet (A) 1 1
2. Number of allowances from the Estimated Deductions Worksheet (B) 2
3. Additional amount to be withheld each pay period (if employer agrees) (C) 3

If employer does not agree, you may file quarterly estimates on Form 540ES with the Franchise Tax Board.

Under the penalties of perjury, I certify that the number of withholding allowances claimed on this certificate does not exceed the number to which I am entitled: or if claiming exemption from withholding, that I am entitled to claim the exempt status.

Signature: Samuel James Cassidy Date: 1-22-01

Employer's Name and Address	California Employer Account Number

cut here

Give the top portion of this page to your employer and keep the remainder for your records.

YOUR CALIFORNIA PERSONAL INCOME TAX MAY BE UNDERWITHHELD IF YOU DO NOT FILE THIS DE 4 FORM

IF YOU RELY ON THE FEDERAL W-4 FOR YOUR CALIFORNIA WITHHOLDING ALLOWANCES, YOUR CALIFORNIA STATE PERSONAL INCOME TAX MAY BE UNDERWITHHELD AND YOU MAY OWE MONEY AT THE END OF THE YEAR.

PURPOSE: This certificate, form DE 4, is for **California personal income tax withholding** purposes only. You should complete this form if:

(1) You claim a different marital status, number of regular allowances, or different additional dollar amount to be withheld for California personal income tax withholding than you claim for Federal income tax withholding.

(2) You claim additional allowances for estimated deductions.

The DE 4 should be used to properly compute the amount of taxes to be withheld from your wages to accurately reflect your State tax situation.

THIS FORM WILL NOT CHANGE YOUR **FEDERAL** WITHHOLDING ALLOWANCES.

The Federal Form W-4 is applicable for California withholding purposes if you wish to claim the same marital status, number of regular allowances, and/or the same additional dollar amount to be withheld for State and Federal purposes. However, Federal tax brackets and withholding methods do not reflect State personal income tax withholding tables. If you rely on the number of withholding allowances you claim on your Federal W-4 withholding allowance certificate for your State income tax withholding, you may be significantly underwithheld. This is particularly true if your household income is derived from more than one source.

CHECK YOUR WITHHOLDING: After your W-4 and/or DE 4 takes effect, compare the dollar amounts that are being withheld with your estimated total annual tax. You can use the worksheets in this DE 4 for California withholding and the Internal Revenue Service (IRS) Publication 919 for Federal withholding calculations.

EXEMPTION FROM WITHHOLDING: If you wish to claim exempt, complete the federal Form W-4. You may only claim exempt from withholding California income tax if you did not owe any Federal income tax last year and you do not expect to owe any Federal income tax this year. The exemption automatically expires on February 15 of the next year unless submitted again on a new W-4 before that date. If you are not having Federal income tax withheld this year, but expect to have a tax liability next year, the law requires you to give your employer a new Form W-4 by December 1.

SANTA CLARA
Valley Transportation Authority

NEW HIRE CHECKLIST

Name: Samuel Cassidy **Start Date:** 1-22-01

Classification: Electro Mechanic **Dept:** Rail Main.

Supervisor: [redacted] **Supv. Phone:** [redacted]

Probationary Period: 1-22-01 **to:** 4-21-01

PERSONNEL COMPLETES:

- ☑ Benefits orientation and form completion. Effective date of coverage 2-22-2001
- ☑ Conflict of Interest (Form 700)
- ☑ Credit Union
- ☑ Employee Assistance Program
- ☑ Employment Forms (I-9, Emergency Contact, Final Warrant, Next of Kin, W-2 etc.)
- ☑ Employment Processes- Bidding, Transfers, Change of Classification
- ☑ Fingerprint check completed 1/12/2001
- NO ☑ Former employee?
  - ☐ Eligible for re-hire? Yes ___/No ___
  - ☐ Adjusted date of hire _____ Salary step _____
  - ☐ Reinstate seniority /benefits? Yes ___/No ___
- ☑ General Orientation scheduled for ~~Feb~~ 12, 13th (Credit Union; Strategic Plan)
- ☑ Hotlines- Open Competitive (321-5665)/ Transfer/Promotional (321-5580)
- ☐ Part-time to full-time information
- ☑ Payday/Salary/Deferred Compensation/Direct Deposit
- ☑ Personnel Policies and Procedures acknowledgment
- ☑ Physical completed 1/12/2001
- ☑ Strategic Plan
- ☐ Transfer/Promotion from ATU to Non-ATU or vice-versa? (Discuss pension issues.)
- ☑ Union representation, contract and dues/ Non-represented status
- ☑ Physician Pre-Selection Form (Workers' Compensation)

Sam Cassidy — 1/22/2001

Completed by (print name) — **Date**

Sam Cassidy — 1/22/2001

Employee Signature — **Date**

Valley Transportation Authority

Physician Pre-Selection for Industrial Injury/Illness

Employee's Name: Sam Cassidy

Badge Number (if applicable): _____

Home Address: 1178 Angmar Ct.
San Jose CA. 95121

Home Telephone: (408) - 629-6522

In the event of an Industrial injury I would like to designate the physician named below as my treating physician, as defined by the California Labor Code Sec. 4600:

Personal Physician means the employee's regular physician or surgeon, who has previously directed the medical treatment of the employee, and who retains the employee's medical records, including his or her medical history.

Physician's Name: [redacted]

Physician's Telephone: _____

☐ I elect not to select a Personal Physician at this time.

Sam Cassidy 1-22-01

Employee's signature *Date*

cc: Environmental Health and Safety (original)
Employee
Workers' Compensation Procedures Binder
Employee's Division File
Personnel

rev. 1/98

Santa Clara Valley Transportation Authority

NEW EMPLOYEE ORIENTATION

Welcome to the Santa Clara Valley Transportation Authority.

You are scheduled for an orientation on Monday, Feb 12 + 13
(day) (date)

from 8:00 to 5:00.
(time)

This orientation will be held at Alexander
(address)
Auditorium

If you have any questions please call J[redacted]

We are looking forward to meeting you.

NAME: Samuel Cassidy
TITLE: Fleet Mechanic
DEPT: Bus Dept
PHONE: 953-4795
715__ACE__ATU__CEMA__SCEAA__

Organizational Development & Training
3331 North First St., Bldg B
San Jose, Calif. 95134

Distribution: White-Employee, Canary-Organizational Development, Pink-Supervisor, Goldenrod-Personnel.

Authorization For Payroll
Deduction of Membership Fees

SANTA CLARA
Valley Transportation Authority

Employee Name Cassidy Samuel J. (Last / First / M.I.) S.S.N. [redacted]

Home Address 1178 Angmar Ct. Badge Number _____

City San Jose State CA Zip Code 95121

Home Phone No. (408) 629-6522 (Area Code)

You are herby authorized to deduct from my wages any monthly dues, fees and assessments that I am required to pay to Amalgamated Transit Union, Division 265.

Signature _____

Date Signed 1-22-2001

For Personnel Use Only

DOH _____

Pos. Code _____

DISTRIBUTION: WHITE:Personnel CANARY: Finance PINK: Employee
Revised: 11/23/97

SANTA CLARA
Valley Transportation Authority

Part of every trip you take®

OATH OF OFFICE

Santa Clara Valley Transportation Authority:

I do solemnly swear (or affirm) that I will support and defend the Constitution of the United States, and the Constitution of the State of California against all enemies, foreign and domestic; that I will bear true faith and allegiance to the Constitution of the United States, and the Constitution of the State of California; that I take this obligation freely, without any mental reservation or purpose of evasion; and that I will well and faithfully discharge the duties upon which I am about to enter.

Sam Cassidy
Name of Appointee

Sam Cass
Signature of Appointee

Electro Mechanic (Rail Maintenance)
Department

Subscribed to and sworn before me, this 22nd day of January 20 01 .

[redacted]
Signature of Person Administering Oath

I:\docs\forms\newhire\oath.doc

SANTA CLARA
Valley Transportation Authority

PHYSICAL AND FINGERPRINT VERIFICATION

I do hereby certify that I have completed the following pre-employment requirements:

1. Pre-employment Physical examination
2. Drug screen test
3. Fingerprint check

I am aware that these requirements must be completed before I can start work on 1/22/2001
(Date)

Sam Cassidy
Applicant's Name (Print)

[redacted] 1/22/2001
Signed/Date

[redacted]
Personnel Witness' Name (Print)

[redacted]
Signed/Date

1-22-01

SANTA CLARA
Valley Transportation Authority

PHYSICAL CLEARANCE WAIVER

I realize that, **prior to my start date**, I must schedule and pass the pre-employment physical.

I am also aware that if I do not pass the physical, my appointment will be revoked.

Sam Cassidy
Applicant's Name (Print)

Sam Cassidy 1/22/01
Signed/Date

SANTA CLARA
Valley Transportation Authority

FINGERPRINT CHECK WAIVER

I am hereby advised by the Personnel Department that my fingerprint results may not be evaluated prior to my start date.

I understand that if there is a discrepancy between the conviction information provided on my application and the results of the fingerprint report, or if there is a disqualifying conviction listed on the fingerprint report, I will be subject to immediate termination.

Sam Cassidy
Applicant's Name (Print)

1/22/2001
Signed/Date

SANTA CLARA
Valley Transportation Authority

December 6, 1995

TO: Newly Hired Transportation Agency Personnel

FROM: Peter M. Cipolla, General Manager

SUBJECT: Personnel Policies and Procedures

Welcome to the Transportation Agency. Attached is a copy of our Personnel Policies and Procedures manual. This manual contains the policies and procedures which govern your employment with the Agency. This manual covers all Agency employees, except where an employee's collective bargaining agreement addresses the same issue. In such cases, the collective bargaining agreement and/or applicable resolution will supersede the policies presented in this manual.

The Agency is committed to providing a discrimination and harassment free work environment. Accordingly, included in this manual are the Agency's policies regarding Unacceptable Work Language, Sexual and Other Forms of Harassment, Equal Opportunity and Affirmative Action, Description of the Discrimination/Harassment Appeals Process, and the complaint handling procedure for reporting violations of those policies.

It is the responsibility of every employee to understand and adhere to these policies. Violations of these policies may result in discipline up to, and including, discharge. I ask that you acknowledge that you have received these policies.

ACKNOWLEDGMENT

I acknowledge that I have received the Personnel Policies and Procedures manual. I understand that it is my responsibility to read, understand and adhere to each of these policies. Should I have any questions regarding any of these policies, I understand that I may contact the Personnel Department, Labor Relations, Equal Opportunities, my supervisor, or my union (if represented by a union) to answer any questions I may have.

1-22-2001
Date Signed

Signature

Sam Cassidy
Print Name

SHARESA FORMS: acknowl.doc
Revised 12/95

SANTA CLARA
Valley Transportation Authority

Part of every trip you take.

Have you ever been employed with the Santa Clara County Transit District?

YES_____ NO X

If yes, what was your job title_____

Badge Number_____ Date of Separation_____

Salary at time of Separation_____

Sam Cassidy
(Signature)

1-22-01
(Date)

Sam Cassidy
(Print Your Name)

SANTA CLARA
Valley Transportation Authority

OUTSIDE EMPLOYMENT STATEMENT

1. NAME	2. SOCIAL SECURITY #	3. DIVISION
Sam Cassidy	[redacted]	Rail Maintenance

4. POSITION Electro-Mechanic | 5. DO YOU NOW HAVE ANY OUTSIDE EMPLOYMENT? YES ☐ NO ☒

6. If the answer to #5 is yes, complete the following:

Employer (Firm) Name: _____ Phone: _____

Employer Address: _____

_____

_____

Nature of the work you do: _____

_____

6a. **Bus Operators engaging in outside employment as a driver** for another property should be aware of Section 21702a of the California Vehicle Code which reads in part:

> "No person shall drive upon any highway any vehicle designed or used for transporting persons for compensation for more than 10 consecutive hours nor for more than 10 hours spread over a total of 15 consecutive hours. Thereafter, such person shall not drive any such vehicle until eight consecutive hours have elapsed.
>
> Regardless of aggregate driving time, a driver shall drive for no more than 10 hours in any 24 hour period unless eight consecutive hours off duty have elapsed."

Generally speaking, the "10 hour rules" will permit you to drive for another property only on your days off. Thus, you are required to report, in writing, to the Division Superintendent on a monthly basis a record of outside driving employment.

6b. **Employees engaging in outside real estate sales, engineering or construction projects** must submit the following information:

Estimated duration of project: _____

Estimate of dollar value of design of construction of project: _____

Location of the construction site: _____

Name and Phone # of construction contractor, if applicable:

_____

I hereby certify to the best of my knowledge the foregoing statements are true and understand that if, at any future time, I engage in, or change outside employment, my immediate supervisor, Department Head, Division Director and the Personnel Department must be notified in writing and the failure to do so is cause for suspension, demotion, or dismissal.

Signature: Sam Cassidy Date: 1-22-2001

Approval is contingent upon the complete separation of your outside activity from your obligations as a Transportation Authority employee. This separation is to include time, facilities and materials. You are required to advise the Authority immediately should your activities, as stated herein, change.

APPROVAL SIGNATURES:

1. Immediate Supervisor ☐ approve ☐ deny _____ (Signature)
2. Department Head ☐ approve ☐ deny _____ (Signature)
3. Division Director ☐ approve ☐ deny _____ (Signature)
4. Personnel Manager ☐ approve ☐ deny _____

[redacted]

SANTA CLARA
Valley Transportation Authority

[redacted]

TREATMENT AUTHORIZATION

Date: 1-11-01 **Patient Name:** Samuel Cassidy

FAXED 1-11-01

***Mail Results to:* [ ] *EMPLOYEE* [ ] *VTA*

SERVICES REQUESTED:

p03 [X] DOT NEW-HIRE W/ DOT DRUG SCREEN

p10 [ ] ~~ADMINISTRATIVE~~ NEW-HIRE

p04 [ ] DOT RECERTIFICATION ONLY

p09 [ ] RESPIRATOR COMPLIANCE EXAM

p08 [ ] AUDIO

p05 [ ] NON-DOT UDS

p01 [X] DOT UDS

[ ] OTHER: _____

SERVICES AUTHORIZED BY: ***(RESULTS MAY BE CALLED TO THE FOLLOWING AUTHORIZED PERSONNEL. **IN ADDITION TO AUTHORIZED PERSONNEL BELOW, ALWAYS CALL RESULTS TO*** [redacted]

[redacted]

_____ Other: _____

Comments / Special Instructions: _____

SANTA CLARA
Valley Transportation Authority

PERSONNEL RECORD ENTRY

DATE: 08/06/08

Cassidy	Samuel	10391
Employee Last Name	First Name, M.I.	ID/Badge Number

Entry Type:
WRITTEN COUNSELING

REASON(S) FOR ENTRY: A review of your attendance record indicates that you have reached 18 points within the one-year review period. The points are as follows:

PRE Date:	Event Date	Event	Time Lost	Points
	07/29/07	OCCURRENCE	3 DAYS	3
	08/06/07	OCCURRENCE	1 DAY	3
	11/05/07	OCCURRENCE	3 DAYS	3
	05/12/08	OCCURRENCE	2 DAYS	3
	06/02/08	OCCURRENCE	1 DAY	3
08/06/08	07/27/08	OCCURRENCE	1 DAY	3
			Total Points:	**18**

ACTION TAKEN:
One of the primary requirements for continued employment is regular attendance In accordance with the current Attendance Program, you are advised that you have reached 18 points within a one-year review period. Be advised that within a one-year review period the accumulation of

- 18 points may result in a written counseling
- 24 points may result in a written warning
- 30 points may result in a one (1) day suspension
- 33 points may result in a three (3) day suspension
- 36 points may result in discharge

Employees may be subject to discharge in lieu of receipt of a third three-day suspension within a one-year review period.

Suspension Date(s):

The oldest event shall be removed when an employee achieves sixty(60) consecutive working days with no events.

In accordance with the Memorandum of Agreement regarding attendance dated April 30, 2002, upon meeting or exceeding the accumulation of 24, 30, 33, or 36 points you have the right to request a hearing on the above charges within thirty (30) calendar days of the date of your receipt of this notice. If such request for hearing is not made within thirty (30) calendar days, all rights to said hearing will be forfeited.

[redacted]
Superintendent - Guadalupe

Distribution: **Original:** Personnel
Copies: Employee
LRVM Administration

Copies (with documentation)
ATU, Local 265
Employee Relations & Organizational Development
Guadalupe

SANTA CLARA
Valley Transportation Authority

VTA
EMPLOYEE SERVICES
2004 DEC -2 P 2:08

PERSONNEL RECORD ENTRY

DATE: 12/01/04

Cassidy	Samuel	10391
Employee Last Name	First Name, M.I.	ID/Badge Number

Entry Type:
WRITTEN COUNSELING

REASON(S) FOR ENTRY: A review of your attendance record indicates that you have reached 18 points within the one-year review period. The points are as follows:

PRE Date:	Event Date	Event	Time Lost	Points
	12/12/03	OCCURRENCE	2 DAYS	3
	01/27/04	OCCURRENCE	5 DAYS	3
	03/23/04	OCCURRENCE	5 DAYS	3
	06/10/04	OCCURRENCE	3 DAYS	3
	09/10/04	OCCURRENCE	3 DAYS	3
12/01/04	11/04/04	OCCURRENCE	1 DAY	3
			Total Points:	**18**

ACTION TAKEN:
One of the primary requirements for continued employment is regular attendance. In accordance with the current Attendance Program, you are advised that you have reached 18 points within a one-year review period. Be advised that within a one-year review period the accumulation of:

- 18 points may result in a written counseling
- 24 points may result in a written warning
- 30 points may result in a one (1) day suspension
- 33 points may result in a three (3) day suspension
- 36 points may result in discharge

Employees may be subject to discharge in lieu of receipt of a third three-day suspension within a one-year review period.

Suspension Date(s):

The oldest event shall be removed when an employee achieves sixty (60) consecutive working days with no events.

In accordance with the Memorandum of Agreement regarding attendance dated April 30, 2002, upon meeting or exceeding the accumulation of 24, 30, 33, or 36 points you have the right to request a hearing on the above charges within thirty (30) calendar days of the date of your receipt of this notice. If such request for hearing is not made within thirty (30)

[redacted]
Light Rail Veh. Maint Supervisor - Guadalupe

Distribution: **Original:** Personnel
Copies: Employee

Copies (with documentation)
ATU, Local 265
Employee Relations & Organizational Development

ESIS Global RiskAdvantage

Santa Clara VTA

Data Valued As Of: 06/13/2005
Version: 12.01
User ID: EVTA001

CLAIM ABSTRACT

CLAIM INFORMATION

File/Claim Number:	9451 635 002017 4 B	**Claimant:**	CASSIDY;SAMUEL	**SSN:**	[redacted]
Claim Adjuster:	[redacted]	**Event Date:**	05/19/2005	**Event Time:**	
Data Loaded:	06/13/2005	**Gender:**	Male	**Age:**	
Coverage:	WC WORKERS COMPENSATION - ESIS	**Claim Type:**	COMP Compensation	**Status:**	Open

CLAIM DETAILS

Report Date:	06/02/2005	**Activity Date:**	06/08/2005	**Employer Aware Date:**	06/02/2005
Close Date:		**Entry Date:**	06/02/2005	**Hire Date:**	01/22/2001
Re-Open Date:		**Claims Made Date:**		**Death Date:**	
Aware to Report Days:	0 Days	**Event to Close:**	N/A	**Report to Close:**	N/A
Claims Made to Close:	N/A	**Event to Report:**	14 Days	**Event to Aware:**	14 Days
				Hire to Event:	1578 Days

Description: UNLOADING JACKS, LIFTING PADS ETC. USING KNEES TO BEND SPRAIN OR STRAIN OF THE KNEE
WC Denial Indicator: N **WC Denial Reason:**
Litigated Claim Indicator:

Catastrophe Number:
Cause: G2 Bodily Reaction - Sudden Muscular Movements - From Voluntary Motions
Hazard: H3 Improper Use of Hands or Body Parts - Using Hands Instead of Hand Tools
Damage/Injury: UV Sprains, Strains (Including Whip Lash) - Knee

Special Analysis: ##########7382########## **(Positions 42-66)**
Plant Division: ##52210####

Location: 5025 LIGHT RAIL VEHICLE MAINTENANCE **Location Of Event:** SAN JOSE, CA
Site: 52210 **Event Zip:** 95134

Event State: CALIFORNIA **Jurisdiction:** CALIFORNIA

Carrier: 200 ESIS
Policy/Contract: 9451 **Policy Period:** **Thru:**

Occupation: ELECTRO MECHANIC **Job Class:** 7382 Bus Co.: All other employees & drivers (Not available in NJ and NY) **Weekly Wage:** 1,300.00

CONTACT INFORMATION

Claim Proc. Office:	635	Northern California		
Supervisor:	883	[redacted]	**Office Phone:**	[redacted]
Representative:	884	[redacted]	**Office Phone:**	

For US Claim Office information, including address and fax number, see the Claim D rectory @ www.esis.com. For ACE International Claim Office Information, including address, fax and phone numbers click on the ACE International Claims Directory.

SIDECAR INFORMATION

VTA Union Job Class:	2
VTA Union Job Class Desc:	
VTA Job Class Code:	202
VTA Job Class Desc:	ELECTRO - MECHANIC
VTA Agency Code:	613
VTA Agency Desc:	BODY MOTION

FINANCIAL INFORMATION

Claim Detail Totals - USD US Dollars

Trans	Type	Status	Paid Indemnity	Paid Medical	Paid Expense	Outstanding Reserves	Recovery	Incurred Net Of Recovery
1	COMP	Open	0.00	0.00	6.00	5,024.00	0.00	5,030.00

Claim Totals - USD US Dollars

	Gross Reserve	Paid	Outstanding Reserves	Incurred	Recovery	Incurred Net Of Recovery
Indemnity	1,680.00	0.00	1,680.00	1,680.00		
Medical	2,600.00	0.00	2,600.00	2,600.00		
Expenses	750.00	6.00	744.00	750.00		
Total	**5,030.00**	**6.00**	**5,024.00**	**5,030.00**	**0.00**	**5,030.00**

CLAIM ABSTRACT TRANSACTIONS CLAIM NOTES TASKS PRINT ABSTRACT FARAMETERS

FAXED 6/2/05

State of California
EMPLOYER'S REPORT OF OCCUPATIONAL INJURY OR ILLNESS

Please complete in triplicate (type if possible) Mail two copies to:
ESIS, Inc. - Claim Service
☐ P.O. Box 4464; Woodland Hills, CA 91365 (818) 712-6300
☒ P.O. Box 5025; Fremont, CA 94537 (510) 790-4600

OSHA CASE NO.

FATALITY ☐

Any person who makes or causes to be made any knowingly false or fraudulent material statement or material representation for the purpose of obtaining or denying workers compensation benefits or payments is guilty of a felony.

California law requires employers to report within **five days** of knowledge every occupational injury or illness which results in lost time beyond the date of the incident **OR** requires medical treatment beyond first aid. If any employee subsequently dies as a result of a previously reported injury or illness, the employer must file within **five days** of knowledge an amended report indicating death. In addition, every serious injury, illness, or death must be **reported immediately** by telephone or telegraph to the nearest office of the California Division of Occupational Safety and Health.

EMPLOYER

1. FIRM NAME: VALLEY TRANSPORTATION AUTHORITY
1a. Policy Number:
Please do not use this column
2. MAILING ADDRESS (Number, Street, City, Zip): 3331 N. FIRST ST. SAN JOSE CA 95134
2a. Phone Number: 408 546 7670
CASE NUMBER
3. LOCATION, if different from Mailing Address (Number, Street, City and Zip): 101 W. YOUNGER AV SAN JOSE, CA 95110
3a. Location Code: 52210
OWNERSHIP
4. NATURE OF BUSINESS; e.g., Painting contractor, wholesale grocer, sawmill, hotel, etc.: PUBLIC TRANSPORTATION
5. State unemployment insurance acct. No: 125039961
6. TYPE OF EMPLOYER: ☐ Private ☐ State ☐ County ☐ City ☐ School District ☒ Other Govt, Specify: PUBLIC TRANS
INDUSTRY

INJURY OR ILLNESS

7. DATE OF INJURY / ONSET OF ILLNESS (mm/dd/yy): 5/31/05
8. TIME INJURY/ILLNESS OCCURRED: 1300 ☒ AM ☐ PM
9. TIME EMPLOYEE BEGAN WORK: 0800 ☒ AM ☐ PM
10. IF EMPLOYEE DIED, DATE OF DEATH (mm/dd/yy): N/A
OCCUPATION
11. UNABLE TO WORK FOR AT LEAST ONE FULL DAY AFTER DATE OF INJURY? ☐ Yes ☒ No
12. DATE OF LAST WORKED (mm/dd/yy): 6/2/05
13. DATE RETURNED TO WORK (mm/dd/yy): N/A
14. IF STILL OFF WORK, CHECK THIS BOX: ☐
15. PAID FULL DAY'S WAGES FOR DATE OF INJURY OR LAST DAY WORKED? ☒ Yes ☐ No
16. SALARY BEING CONTINUED? ☒ Yes ☐ No
17. DATE OF EMPLOYER'S KNOWLEDGE /NOTICE OF INJURY/ILLNESS (mm/dd/yy): 6/2/05
18. DATE EMPLOYEE WAS PROVIDED CLAIM FORM (mm/dd/yy): 6/2/05
SEX
19. SPECIFIC INJURY/ILLNESS AND PART OF BODY AFFECTED, MEDICAL DIAGNOSIS if available, e.g., Second degree burns on right arm, tendonitis of left elbow, lead poisoning: KNEES - MORE LEFT THAN RIGHT
AGE
20. LOCATION WHERE EVENT OR EXPOSURE OCCURRED (Number, Street, City, Zip): 101 W. YOUNGER AV SJ 95110
20a. COUNTY: SANTA CLARA
21. ON EMPLOYER'S PREMISES? ☒ Yes ☐ No
DAILY HOURS
22. DEPARTMENT WHERE EVENT OR EXPOSURE OCCURRED, e.g., Shipping department, machine shop.: LRVM - SHOP
23. Other Workers Injured/Ill in this event? ☐ Yes ☒ No
DAYS PER WEEK
24. EQUIPMENT, MATERIALS AND CHEMICALS THE EMPLOYEE WAS USING WHEN EVENT OR EXPOSURE OCCURRED, e.g., Acetylene, welding torch, farm tractor, scaffold: TRAIN LEVELING EQUIPMENT
WEEKLY HOURS
25. SPECIFIC ACTIVITY THE EMPLOYEE WAS PREFORMING WHEN EVENT OR EXPOSURE OCCURRED, e.g., Welding seams of metal forms, loading boxes onto truck: LEVELING TRAIN
WEEKLY WAGE
26. HOW INJURY/ILLNESS OCCURRED. DESCRIBE SEQUENCE OF EVENTS. SPECIFY OBJECT OR EXPOSURE WHICH DIRECTLY PRODUCED THE INJURY/ILLNESS, e.g., Worker stepped back to inspect work and slipped on scrap metal. As he fell, he brushed against fresh weld, and burned right hand. USE SEPARATE SHEET IF NECESSARY.: SEE EMPLOYEE NOTICE TO EMPLOYER SUPPLEMENT.
COUNTY
27. NAME AND ADDRESS OF PHYSICIAN (Number, Street, City, Zip)
27a. Phone Number
NATURE OF INJURY
28. HOSPITALIZED AS AN INPATIENT OVERNIGHT? ☐ No ☐ Yes If yes then, NAME AND ADDRESS OF HOSPITAL (Number, Street, City, Zip)
28a. Phone Number
29. Employee treated in Emergency Room? ☐ Yes ☐ No
PART OF BODY

RECEIVED
RISK MGMT
JUN - 1 2005
BY

ATTENTION: This form contains information relating to employee health and must be used in a manner that protects the confidentiality of employees to the extent possible while the information is being used for occupational safety and health purposes.
See CCR Title 8 14300.29(b)(6)-(10) & 14300.35(b)(2)(E)2.
#10391
Note: Shaded boxes indicate confidential employee information as listed in CCR Title 8 14300.35(b)(2)(E)2.*
SOURCE

EMPLOYEE

30. EMPLOYEE NAME: 10391 SAMUEL CASSIDY
31. [redacted]
32. DATE OF BIRTH (mm/dd/yy): 8/21/63
EVENT
33. HOME ADDRESS (Number, Street, City, Zip): 178 KNIGHT CT SAN JOSE, CA 95121
33a. Phone Number: 408 624 6522
SECONDARY SOURCE
34. SEX: ☒ Male ☐ Female
35. OCCUPATION (Regular job title, NO initials, abbreviations or numbers): ELECTRO MECHANIC (ATU)
36. DATE OF HIRE (mm/dd/yy): 01/22/2001
11/22/01
37. EMPLOYEE USUALLY WORKS: 8 hours per day, 5 days per week, 40 total weekly hours
37a. EMPLOYMENT STATUS: ☒ regular, full-time ☐ part-time ☐ temporary ☐ seasonal
37b. UNDER WHAT CLASS CODE OF YOUR POLICY WERE WAGES ASSIGNED?
EXTENT OF INJURY
38. GROSS WAGES/SALARY: $ 3392 per M
39. OTHER PAYMENTS NOT REPORTED AS WAGES/SALARY (e.g., tips, meals, overtime, bonuses, etc.)? ☐ Yes ☒ No

Completed By (type or print): [redacted]
Sign: [redacted]
Date (mm/dd/yy): 6/2/05

*Confidential information may be disclosed only to the employee, former employee, or their personal representative (CCR Title 8 14300.35), to others for the purpose of processing a workers' compensation or other insurance claim; and under certain circumstances to a public health or law enforcement agency or to a consultant hired by the employer (CCR Title 8 14300.30). CCR Title 8 14300.40 requires provision upon request to certain state and federal workplace safety agencies.

FORM 5020 (REV 7) February 2003 FILING OF THIS FORM IS NOT AN ADMISSION OF LIABILITY

FORWARD TO ESIS FOR STATE FILING

State of California
Department of Industrial Relations
DIVISION OF WORKERS' COMPENSATION

FAXED 6/2/05

Estado de California
Departamento de Relaciones Industriales
DIVISION DE COMPENSACIÓN AL TRABAJADOR

WORKERS' COMPENSATION CLAIM FORM (DWC 1)

PETITION DEL EMPLEADO PARA DE COMPENSACIÓN DEL TRABAJADOR (DWC 1)

Employee: Complete the "Employee" section and give the form to your employer. Keep a copy and mark it **"Employee's Temporary Receipt"** until you receive the signed and dated copy from your employer. You may call the Division of Workers' Compensation and hear recorded information at **(800) 736-7401.** An explanation of workers' compensation benefits is included as the cover sheet of this form.

You should also have received a pamphlet from your employer describing workers' compensation benefits and the procedures to obtain them.

Empleado: *Complete la sección* ***"Empleado"*** *y entregue la forma a su empleador. Quédese con la copia designada* ***"Recibo Temporal del Empleado"*** *hasta que Ud. reciba la copia firmada y fechada de su empleador. Ud. puede llamar a la División de Compensación al Trabajador al* ***(800) 736-7401*** *para oir información gravada. En la hoja cubierta de esta forma esta la explicación de los beneficios de compensación al trabajador.*

Ud. también debería haber recibido de su empleador un folleto describiendo los beneficios de compensación al trabajador lesionado y los procedimientos para obtenerlos.

Any person who makes or causes to be made any knowingly false or fraudulent material statement or material representation for the purpose of obtaining or denying workers' compensation benefits or payments is guilty of a felony.

Toda aquella persona que a propósito haga o cause que se produzca cualquier declaración o representación material falsa o fraudulenta con el fin de obtener o negar beneficios o pagos de compensación a trabajadores lesionados es culpable de un crimen mayor "felonia".

Employee—complete this section and see note above ***Empleado—complete esta sección y note la notación arriba.***

1. Name. *Nombre.* Sam Cassidy — Today's Date. *Fecha de Hoy.* 6/2/05
2. Home Address. *Dirección Residencial.* 1178 Angmar Ct S.J. 95121
3. City. *Ciudad.* San Jose — State. *Estado.* CA — Zip. *Código Postal.* 95121
4. Date of Injury. *Fecha de la lesión (accidente).* 5/19/05 — Time of Injury. *Hora en que ocurrió.* 7:00 (a.m.) p.m.
5. Address and description of where injury happened. *Dirección/lugar dónde ocurrió el accidente.* Light Rail Yard 101 W. Younger Ave S.J. CA 95110
6. Describe injury and part of body affected. *Describa la lesión y parte del cuerpo afectada.* Knees painful, especially Lt. knee which feels swollen.
7. Social Security Number. *Número de Seguro Social del Empleado.* [redacted]
8. Signature of employee. *Firma del empleado.* Sam Cass

RECEIVED VIA RISK MGMT JUN - 1 2005 BY

Employer—complete this section and see note below. ***Empleador—complete esta sección y note la notación abajo.***

9. Name of employer. *Nombre del empleador.* Valley Transit Authority
10. Address. *Dirección.* 101 W. Younger Ave SJ CA 95110
11. Date employer first knew of injury. *Fecha en que el empleador supo por primera vez de la lesión o accidente.* 6/2/05
12. Date claim form was provided to employee. *Fecha en que se le entregó al empleado la petición.* 6/2/05
13. Date employer received claim form. *Fecha en que el empleado devolvió la petición al empleador.* 6/2/05
14. Name and address of insurance carrier or adjusting agency. *Nombre y dirección de la compañía de seguros o agencia administradora de seguros.*
ESIS ☐ P.O. Box 4464, Woodland Hills, CA 91365 ☒ P.O. Box 5025, Fremont, CA 94537 ☐ P.O. Box 911, Portland, OR 97207
15. Insurance Policy Number. *El número de la póliza de Seguro.* PSI
16. Signature of employer representative. *Firma del representante del empleador.* [redacted]
17. Title. *Título.* Supervisor — 18. Telephone. *Teléfono.* [redacted]

Employer: You are required to date this form and provide copies to your insurer or claims administrator and to the employee, dependent or representative who filed the claim within **one working day** of receipt of the form from the employee.

SIGNING THIS FORM IS NOT AN ADMISSION OF LIABILITY

Empleador: *Se requiere que Ud. feche esta forma y que provéa copias a su compañía de seguros, administrador de reclamos, o dependiente/representante de reclamos y al empleado que hayán presentado esta petición dentro del plazo de* ***un día hábil*** *desde el momento de haber sido recibida la forma del empleado.*

EL FIRMAR ESTA FORMA NO SIGNIFICA ADMISION DE RESPONSABILIDAD

☐ Employer copy/*Copia del Empleador* ☐ Employee copy/ *Copia del Empleado* ☐ Claims Administrator/*Administrador de Reclamos* ☐ Temporary Receipt/*Recibo del Empleado*

DWC Form 1 Rev. 7/1/04

DWC Forms 1 Rev. 7/1/04

JF-601282

FAXED 6/2/05

Employee's Report Of Industrial Injury
Notice to Employer Supplement

Employee Name: Sam Cassidy	Badge #: 10391			Date of Hire: 1/21/01	
Home Address # / Street Name: 1178 Angmar Ct	City: San Jose	State: CA	Zip Code: 95121	Sex (Circle One): (Male) Female	
Home Phone #: (408) 629-6522	Social Security #: [redacted]			Date Of Birth (Mo/Da/Yr): 8/29/63	

Division / Department / Shop: **Guadalupe Rail / Vehicle Maintenance /**

Job Classification: Electro-Mechanic.	Start of Shift (Date / Time): 7:30 AM 5/19/05

Nature of Injury and Parts of Body Affected (Strain, Burn, Fracture, etc.)
Knees, especially Left knee painfull & feels swollen.

Where Did Accident or Exposure Occur? (Number Street City Facility etc.) Light Rail
101 west Younger Ave. San Jose CA 95110

Area of Facility where Accident or Exposure Occur? (Shop Track, Track Pits, Blowdown, Daily Insp. Bldg, Car Storage Tracks, Car Wash etc.)+A39
shop track #8

Specific Activity You Were Performing When Event or Exposure Occurred. (Welding, Lifting, Walking etc.)
Unloading jacks, lifting pads, & metal spacers from cart & placing them on train & shop floor.

How Did Accident or Exposure Occur? While bending my knees during unloading (lifting) equipment, both knees were sore. I thought it was just sore muscles, because I was fairly new to this particular job assignment. The knees seemed to get better, then would get worse, especially my left knee which now is getting swollen.

Object of Substance that Directly Injured You
The actual unloading process from the equipment cart to the train and floor.

Name of Witnesses
1) [redacted]
2)
3)
4)

RECEIVED VTA RISK MGMT JUN - 1 2005 BY

Why in Your Opinion Did this Accident or Exposure Occur
I don't know. I was trying to use my knees as to protect my back.

Will Doctor be Seen ? If Yes, Give Name and Address — Doctor's Name / Clinic or Hospital
Circle one: (Yes) No — [redacted]
Address (Number, Street Name, City, Zip Code): [redacted]

Time Lost Due To Injury? If Yes, Last Day Worked. Circle one: Yes (No)	Date (Mo/Da/Yr): 6/2/05	Date and Time of Injury (Mo/Da/Yr – Hr:Min – AM / PM): 5/19/05 7:30AM	
Employee Signature: [signature]	Su [redacted]		Date (Mo/Da/Yr): 6/2/05

EmpRptSupplement Rev. #1 04/01/2002

SANTA CLARA
Valley Transportation Authority

FAXED 6/2/05

Guadalupe Rail Division
Vehicle Maintenance Department
101 West Younger Avenue
San Jose, CA 95110-1719

RECEIVED
VTA RISK MGMT
JUN - 1 2005
BY

Fax Cover Sheet

FROM: [redacted]

Phone: [redacted]
Fax: [redacted]
e-mail: [redacted]

TO:	**VTA – Risk Management –**	**ESIS, Inc. First report of Claim**
Phone:	[redacted]	Phone: [redacted]
Fax:	408-955-9767	Fax: 510-790-8740

SUBJECT: **Samuel Cassidy Badge # 10391 DOI 05/19/2005 DOR 06/02/2005**

COMMENTS: State form faxed. Employee form faxed

4 PAGES INCLUDING COVER SHEET DATE: 06/02/2005

[redacted]

FAXED 6/2/05

RECEIVED VT RISK MGMT JUN 03 2005 BY

STATE OF CALIFORNIA
Division of Workers' Compensation
PRIMARY TREATING PHYSICIAN'S PROGRESS REPORT (PR-2)

Patient Last Cassidy First Samuel M.I. Date of Exam: 6/02/05 Case #: 43131243

SS# [redacted] Date of Birth 8/29/63 Date of Injury 5/19/05 Claim #

Employer: VALLEY TRANSPORTATION AUT Contact: [redacted] Tel: [redacted] Fax: [redacted]

Claims Administrator ESIS /ACE USA Tel: (510) 790-4600 Fax:

REASON FOR SUBMITTING REPORT (Check all that apply. If any box aside from "Other" applies, this report qualifies as mandatory.)

- ☐ Significant change in patient's condition
- ☐ Significant change in work status
- ☐ Significant change in treatment plan
- ☐ Need for referral or consultation
- ☐ Need for surgery or hospitalization
- ☐ Periodic Report (45 days after last report)
- ☐ Info. requested by:
- ☐ Discharged
- ☐ Request for Authorization
- ☐ Other: DFR

PATIENT STATUS Since the last exam, this patient's condition has:

- ☐ improved as expected
- ☐ worsened
- ☐ improved, but slower than expected
- ☐ reached plateau and no further improvement is expected
- ☐ not improved significantly
- ☐ been determined to be non-work related

SUBJECTIVE COMPLAINTS (Document and describe significant complaints if this report qualifies as mandatory.)

Rt Knee pain & swelling / p
report the bending of knee 2 wks

OBJECTIVE FINDINGS (Document significant exam findings, lab, imaging, and other diagnositic testing if this report qualifies as mandatory.)

DIAGNOSES (Include ICD-9 code, if possible)

Rt Knee strain

TREATMENT

- ☐ Office Visit / Injury Treatment ☐ Start / ☐ Continue Therapy 3 times / week for 2 weeks ☐ Other
- ☐ Medications / Supplies Dispensed Motrin 600 TID
- ☐ Consultation / ☐ Referral ☐ Requested / ☐ Pending. Specialty ☐ Work status to be determined by specialist.

Estimated length of treatment is now weeks

WORK STATUS ☐ First Aid Case

- ☐ Return / ☐ Continue to work without restrictions.
- ☐ Off the balance of this shift only. Then RTW on ☐ Full / ☐ Modified duty. ☐ Re-evaluate work status before next shift.
- ☐ Off work. Estimated period of total temporary disability days.
- ☐ Return to work as of 8/6/2 with the restrictions indicated below. Estimated duration of modified duty is days.

( ) No work near moving machinery
( ) No / ( ) Limited use of R / L hand to hrs/day
( ) No / ( ) Limited standing or walking to hrs/day
( ) No / ( ) Limited overhead work to hrs/day
( ) No / ( ) Limited stooping and bending to hrs/day
( ) No / ( ) Limited kneeling or squatting to hrs/day
( ) No / ( ) Limited ☐ Lift ☐ Pull ☐ Push
Up to: ☐ 10 lbs ☐ 25 lbs ☐ 50 lbs ☐ lbs
( ) No climbing

( ) Sit down job
( ) Must wear ☐ Splint ☐ Immobilizer ☐ Back support ☐ Cage ☐ Other
( ) Must keep elevated
( ) Keep wound\bandage clean and dry
( ) Must take a minute stretch break every minutes from ( ) Keyboard / ( )
( ) Other

☐ Medical status was discussed with employer representative

If no modified work is made available, employer must keep employee off work unless, and until, such modified work is made available.

DISCHARGE STATUS

- ☐ Patient discharged as cured without ratable disability.
- ☐ Patient discharged as permanent and stationary with ratable disability and/or need for future medical care. A PR-3 to follow.
- ☐ **NON-INDUSTRIAL** Patient instructed to see physician at own expense.

PRIMARY TREATING PHYSICIAN

I declare under penalty of perjury that this report is true and correct to the best of my knowledge and that I have not violated Labor Code S 139.3.

Name [redacted] Cal. Lic # [redacted] Date of Exam 6/02/05

Specialty Signature [redacted]

[redacted]

YOUR NEXT APPOINTMENT WITH THE DOCTOR IS ON:

☐ MON ☐ TUE ☐ WED ☐ THUR ☐ FRI ☐ SAT
DATE: 6/10 TIME: 7-3 ☐ Before / After Shift
PLEASE CALL IN ADVANCE IF YOU WILL BE UNABLE TO KEEP THIS APPOINTMENT.

YOUR NEXT APPOINTMENT FOR PHYSICAL THERAPY IS ON:

☐ MON ☐ TUE ☐ WED ☐ THUR ☐ FRI ☐ SAT
DATE: TIME: ☐ Before / After Shift
PLEASE CALL IN ADVANCE IF YOU WILL BE UNABLE TO KEEP THIS APPOINTMENT.

[redacted]

From: [redacted]
Sent: Monday, July 18, 2005 12:39 PM
To: [redacted]
Subject: RE: Samuel Cassidy 94516350020174

Mr. Cassidy is maintenance so only exceptions are entered for him.

The absence/attendance report has no records, but I'm faxing it to you anyway.

Please contact [redacted] at Guadalupe for more detail

[redacted]
Risk Management
phone 4[redacted]
fax [redacted]

-----Original Message-----
From: [redacted]
Sent: Monday, July 18, 2005 11:48 AM
To: [redacted]
Subject: Samuel Cassidy 94516350020174

Good morning [redacted] Happy Monday???? ☺ I am looking for his time card from 5/19/05 through current date.....could you please have it faxed over to me? Thanks!

Program ID: ZPPRATAB ATT ABS RECS
Page: 1

Santa Clara Valley Transportation Authority
Employee Attendance and Absence Report
For period: 05/19/2005 - 07/17/2005

Run Date: 07/18/2005 Time: 12:3
User: [redacted] System: 40

WDN#	Cost Ctr	Pers. #	Name	Date (From - To)	Attendance Code	Attendance Hours	Absence Code	Absence Hours	Total Hc

No records found.

Errors & Warnings

No errors or warnings to report

[redacted]

188

****
*** TX REPORT ***
****

TRANSMISSION OK

TX/RX NO	2826
RECIPIENT ADDRESS	15107908740
DESTINATION ID	ESIS
ST. TIME	07/18 11:40
TIME USE	00'25
PAGES SENT	1
RESULT	OK

Program ID: ZPPRATAB ATT ABS RECS
Page: 1

Santa Clara Valley Transportation Authority
Employee Attendance and Absence Report
For period: 05/19/2005 - 07/17/2005

WDN# Cost Ctr Pers. # Name Date (From - To) Attend Code

No records found.

Errors & Warnings

No errors or warnings to report

USHW of California - San Jose Case # 43131243

DOCTOR'S FIRST REPORT OF OCCUPATIONAL ILLNESS OR INJURY

2. EMPLOYER	VALLEY TRANSPORTATION AUT	1. INSURER	ESIS /ACE USA	PLEASE DO NOT USE THIS COLUMN
3. Street Address City, State, Zip 4. Business Type	3331 N. FIRST STREET BLDG SAN JOSE CA 95134	Street Address City, State, Zip Claim #	P.O. BOX 5025 FREMONT CA 94537	Case No.
5. PATIENT NAME (First, Middle, Last)	Cassidy, Samuel	6. Sex ☒ Male ☐ Female	7. Date of Birth 8/29/63	Industry
8. Address: No. and Street City / Zip	1178 Angmar ct San jose 95121	9. Telephone Number	(408) 546-7670	County
10. Occupation (Specific Job Title)	Mechanic	11. Social Security Number	[redacted]	Age
12. Injured at: / City / County	101 W. Younger Ave. SAN JOSE Santa Clara			Hazard
13. Date and hour of injury or onset of illness	5/19/05 7:30 AM	14. Date last worked Mo. Day Yr.	6/02/05	Disease
15. Date and hour of first examination or treatment	6/02/05 10:24 AM	16. Have you (or your office) previously treated patient? ☐ Yes ☒ No		Hospitalization
17. PATIENT, PLEASE DESCRIBE HOW THE ACCIDENT OR EXPOSURE HAPPENED (Be specific)	Patient states, "I was lifting shop equipment (jacks, lifting pads, metal spacers) from a cart onto the train and onto shop floor. While bending with my knees to protect my back, I noticed both knees were sore. I thought it was just sore muscles as ... #19132 Blue/[redacted]			Occupation Return Date Code

18./19./20. SUBJECTIVE COMPAINTS/OBJECTIVE FINDINGS/DIAGNOSIS Chemical or toxic compounds involved? ☐ Yes ☒ No

ALLERGIES: NKDA. MEDS: Pamelor
BP: 130/80, P: 76, T: 98.6
HISTORY/COMPLAINTS: Pain and swelling to left knee xZ weeks. Onset after repetitive bending of knees at work. Patient lifting jacks, pads, metal spacers. Left knee pain and swelling is sharp, mild, intermittent; exacerbated by bending.
EXAMINATION: Left knee: Swelling. Tenderness of the medial and lateral joint lines. Effusion present. No tenderness or deformity of the popliteal fossa. No asymmetry, atrophy, or lesions of the quadriceps. No patellar subluxation or tenderness. Normal range of motion of the knee, pain with full flexion.
Negative abduction/adduction stress, McMurray, bulge sign/ballottment, ant/post drawer sign, apprehension, patello-femoral grind test. No muscle weakness. No sensory changes to light touch or pinprick. Normal distal pulses and capillary refilling of digits. No signs of lymphedema or inguino/crural lymphadenopathy.
DIAGNOSIS: SPRAIN/STRAIN LEFT KNEE

Diagnosis: 844.9 STRAIN/KNEE

X-ray and laboratory results (state if none or pending) X-ray left knee, 3 views.

RECEIVED
VTA RISK MGMT
JUL 21 2005
BY

21. Findings consistent with patient's statement?	22. Other condition that will impede recovery	Explain:
☒ Yes ☐ No	☐ Yes ☒ No	

23. TREATMENT RENDERED

Comprehensive examination, history, and evaluation were performed of the injured area. Pertinent orthopedic and neurological testing were performed. Dispensed Ibuprofen 600 mg #40 t.i.d. Physical therapy 3 times/week for 2 weeks. Patient given after care instructions and informed about medication side effects. Recheck in clinic on 06/15/05.
WORK STATUS: Limited kneeling and squatting.

24. If further treatment required, specify treatment. Physical therapy 3x2
25. If hospitalized as inpatient, give hospital name and location.

Estimated Days 14
Date Admitted Estimated stay

26. WORK STATUS Is patient able to perform usual work? ☐ Yes ☒ No If no, extended return date to:
Regular Work Mod Work 6/02/05 Specify Restrictions: See above

Doctor's Signature Signature on File
Name and Degree [redacted]
Address [redacted] San Jose CA 95112

CA License [redacted]
IRS Number [redacted]
Phone Number [redacted]

ANY PERSON WHO MAKES OR CAUSES TO BE MADE ANY KNOWINGLY FALSE OR FRAUDULENT MATERIAL STATEMENT OR MATERIAL REPRESENTATION FOR THE PURPOSE OF OBTAINING OR DENYING WORKERS COMPENSATION BENEFITS OR PAYMENTS IS GUILTY OF A FELONY.

****
*** TX REPORT ***
****

TRANSMISSION OK

TX/RX NO	3019
RECIPIENT ADDRESS	15107908740
DESTINATION ID	ESIS
ST. TIME	08/22 08:33
TIME USE	00'25
PAGES SENT	1
RESULT	OK

Program ID: ZPPRATAB ATT ABS RECS
Page: 1

Santa Clara Valley Transportation Authority
Employee Attendance and Absence Report
For period: 01/01/2005 - 12/31/2005

WDN#	Cost Ctr	Pers. #	Name	Date (From - To)	Attend. Code
1700	52210	10391	Cassidy, Samuel J.	02/04/2005 to 02/04/2005	
1700	52210	10391	Cassidy, Samuel J.	03/18/2005 to 03/18/2005	
1700	52210	10391	Cassidy, Samuel J.	05/06/2005 to 05/06/2005	

Errors & Warnings

No errors or warnings to report

EXH 1

Program ID: ZPPRATAB ATT ABS RECS
Page: 1

Santa Clara Valley Transportation Authority
Employee Attendance and Absence Report
For period: 01/01/2005 - 12/31/2005

Run Date: 08/22/2005 Time: 09:2
User: [redacted] System: 40

WDN#	Cost Ctr	Pers. #	Name	Date (From - To)	Attendance Code	Attendance Hours	Absence Code	Absence Hours	Total Hc
1700	52210	10391	Cassidy, Samuel J.	02/04/2005 to 02/04/2005			FLH	8.00	
1700	52210	10391	Cassidy, Samuel J.	03/18/2005 to 03/18/2005			FLH	8.00	
1700	52210	10391	Cassidy, Samuel J.	05/06/2005 to 05/06/2005			FLH	8.00	
		10391	Cassidy, Samuel J.					24.00	24

Errors & Warnings

No errors or warnings to report

FLH - floating holiday

To [redacted]

198

[redacted]

WORK STATUS REPORT

FAXED 9/16/05 SC

Name. Last: Cassidy First: Samuel Date of Exam: 9/16/05 Case #: 43131243

SS#: [redacted] Date of Birth: 8/29/63 Date of Injury: 5/19/05 Claim #: 94516350020174

Employer: VALLEY TRANSPORTATION AUT Contact: [redacted] Tel.: [redacted] Fax: [redacted]

Claims Administrator: ESIS /ACE USA Tel.: (510) 790-4600 Fax: _____

PATIENT STATUS Since the last exam, this patient's condition has:

- ☐ Improved as expected
- ☐ Improved, but slower than expected
- ☐ work status pending PR2
- ☒ not improved significantly
- ☐ worsened
- ☐ reached plateau and no further improvement is expected
- ☐ been determined to be non-work related

DIAGNOSES (include ICD-9 code, if possible)

836.0 TEAR/MEDIAL MENISCUS

TREATMENT

☒ Office Visit / Injury Treatment ☐ Start / ☐ Continue Therapy : ___ times / week for _____ weeks ☐ Other _____

☒ Medications / Supplies Dispensed pt needs to schedule another pre-op and needs to schedule date for ex

☐ Consultation / ☐ Referral ☐ Requested / ☐ Pending. Specialty _____ ☐ Work status to be determined by specialist.

Estimated length of treatment is now _____ weeks

WORK STATUS ☐ First Aid Case

☐ Return / ☒ Continue to work without restrictions.

☐ Off the balance of this shift only. Then RTW on ☐ Full / ☐ Modified duty. ☐ Re-evaluate work status before next shift.

☐ Off work. Estimated period of total temporary disability _____ days.

☐ Return to work as of _____ with the restrictions indicated below. Estimated duration of modified duty is _____ days.

- ( ) No work near moving machinery
- ( ) No / ( ) Limited use of R / L hand to ___ hrs/day
- ( ) No / ( ) Limited standing or walking to ___ hrs/day
- ( ) No / ( ) Limited overhead work to ___ hrs/day
- ( ) No / ( ) Limited stooping and bending to ___ hrs/day
- ( ) No / ( ) Limited kneeling or squatting to ___ hrs/day
- ( ) No / ( ) Limited ( ) Lift ( ) Pull ( ) Push Up to: ( ) 10 lbs ( ) 25 lbs ( ) 50 lbs ( ) ___ lbs
- ( ) No climbing
- ( ) Sit down job.
- ( ) Must wear: ( ) Splint ( ) Immobilizer ( ) Back support ( ) Cage ( ) Other _____
- ( ) Must keep _____ elevated
- ( ) Keep wound/bandage clean and dry
- ( ) Must take a ___ minute stretch break every ___ minutes from ( ) Keyboard / ( ) _____
- ( ) Other _____

☐ Medical status was discussed with employer representative. Name _____

If no modified work is made available, employer must keep employee off work unless, and until, such modified work is made available.

DISCHARGE STATUS

☐ Patient discharged as cured without ratable disability.

☐ Patient discharged as permanent and stationary with ratable disability and/or need for future medical care. A PR-3 to follow.

☐ NON-INDUSTRIAL. Patient instructed to see physician at own expense.

TREATING PROVIDER

Name [redacted] Lic. # [redacted] Date of Exam 9/16/05

Specialty _____ Signature Signature on File

Issued at: [redacted]

Arrival Time 9:03 AM Release Time 9:43 AM

RECEIVED
VTA Risk Management
SEP 16 2005
By _____

ESIS SCVTA WC Claims
P.O. Box 31083
Tampa, FL 33631-3083

(510) 790-8741
(800) 335-3418 *fax*
[redacted]
www.ace-ina.com

[redacted]
Claims Examiner

October 30, 2006

Samuel Cassidy
1178 Angmar Ct.
San Jose, CA 95121

RISK MGMT REC'D '06 NOV 1

Employer: **Santa Clara VTA**
D/Injury: **05-19-05**
Claim Number: **9451-635-002017-4**

Notice of Non-eligibility for the Supplement Job Displacement Benefit

Dear Mr. Cassidy:

California law provides that you are eligible for a Supplemental Job Displacement Benefit voucher if your injury causes Permanent Disability and your employer is not able to provide you with medically appropriate work. This letter is to advise you regarding the availability of work within your work restrictions. **Only the item checked below applies to you**:

_____ You have been released to modified duties on a temporary basis. Your employer has a temporary modified or alternative position that accommodates your work restrictions. If you have not already done so, please contact your employer as soon as possible to arrange a return to work date. We do not know if you will have permanent disability, we therefore cannot determine if you will need a permanently modified or alternative position because we do not have your final work restrictions. We will contact you as soon as we have this information and will notify you regarding your eligibility for a Supplemental Job Displacement Benefit voucher at that time.

XX You have been released to your regular duties. If you have not already done so, please contact your employer as soon as possible to arrange a return to work date. You are not eligible for a Supplemental Job Displacement Benefit voucher. If your employer has 50 or more employees, an offer of work by your employer may result in a 15% reduction in your weekly permanent disability payments.

_____ Your employer does not have work available within your work restrictions. You will be sent a Supplemental Job Displacement Benefit voucher, which can be used for training or skills enhancement to prepare you for a new job, as soon as your level of Permanent Disability has been determined by the Workers' Compensation Appeals Board. If your employer has 50 or more employees, the lack of appropriate work with your employer may result in a 15% increase in your weekly permanent disability payments.

"If you are covered under a collective bargaining agreement please refer to it for further information, i.e. ATU members please see section 8.3c of your contract".

_____ Your employer has a permanent modified or alternative position that accommodates your work restrictions, lasting at least 12 months. Information regarding this position is attached (Notice of Offer of Modified or alternate work DWC-AD 10133.53). Please complete the enclosed Notice of Offer of Modified or Alternative Work and return to me immediately. You currently are not eligible for a Supplemental Job Displacement Benefit Voucher.

Please call me, or your attorney if you have one, if you have questions. If you want further information, you may contact the local state information and Assistance office by calling (408) 277-1243 or you may receive recorded information by calling (800) 736-7401.

Sincerely,

[redacted]
Sr. Claims Rep

Attachment(s):

Notice of Potential Rights to Supplemental Job Displacement Benefit DWC-D10133.52
Notice of Offer of Modified or Alternative Work DWC-AD 10133.53
XX Request for Dispute Resolution before the Administrative Director DWC- AD 10133.55
Proof of Service

CC: Santa Clara VTA

Addendum

***If you are covered under a collective bargaining agreement please refer to it for further information, i.e. ATU members please see section 8.3c* of your contract.**

ESIS / ACE USA
P.O. Box 31083
Tampa, FL 33631-3083

PROOF OF SERVICE BY MAIL

I declare that: [redacted]

I am employed in the County of Alameda, California.

I am over the age of eighteen years and an employee of ESIS / ACE USA, who is a party to this action, and I have no personal interest in this matter; my business address is 39300 Civic Center Drive, Suite 300, Fremont, California, 94538. On 10/30/06 I served the above-mentioned notice of non-eligibility for the supplement job displacement benefit on the parties in said cause by placing a true copy thereof enclosed in a sealed envelope with postage thereon fully prepaid, in the United States mail at Fremont, California, addressed as follows:

Samuel Cassidy
1178 Angmar CT.
San Jose, CA 95121

I declare under penalty of perjury that the foregoing is true and correct and that this declaration was executed on 10/30/06, at Fremont, California.

[redacted]

ESIS/ACE USA

File No.: 9451 635 0020174

[redacted]

Cassidy, Samuel

From: [redacted]
Sent: Tuesday, December 06, 2005 10:51 AM
To: [redacted]
Subject: 10391

IIN = 5.0 hr
III = 3.0 hr

Since he is out for surgery, can I assume you already coded his first three days out as ISP? If he didn't lose time before this, then use ISP for 8 hours for the first three days that he is out, as long as they are his scheduled work days. Then begin integration.

[redacted]
Risk Management
phone [redacted]
fax [redacted]

ESIS
An Insurance Services Company

Routing 1040 [redacted] PO Box 5025 [redacted]
510.790.8741 *tel*
510.790.8740 *fax*
[redacted]

[redacted]
Sr. Claims Examiner

January 12, 2006

Samuel Cassidy
1178 Angmar Ct
San Jose, CA 95121

Employee: **Samuel Cassidy**
D/injury: **5-19-05**
Claim no: **9451-635-002017-4**
Employer: **Santa Clara VTA**

FIRST AND FINAL PERMANENT DISABILITY ADVANCE

Dear Mr. Cassidy:

ESIS is handling your workers' compensation claim on behalf of your employer. This notice is to advise you of the status of permanent disability payments for your workers' compensation injury of 3-16-05

Please be advised that we will not be providing you permanent disability advances until we have determine the extent, if any, of any permanent disability. Since you have been overpaid in temporary disability in the amount of $1,200.00 we will take credit from any permanent partial disability that you are entitled to. The overpayment covers the period from 1-2-06 through 1-11-06.

Your weekly compensation rate is **$220.00** based on your earnings of **$1,300.00.** A total of $1200.00 has been paid in permanent disability. If you would like to reimburse this amount you may send a check for $1200.00 to ESIS, P. O. Box 5025, Fremont, CA 94537 or you can make arrangements to pay it installments.

If you disagree with this decision and you are represented by legal counsel, please call him/her. Otherwise, if you have any questions, please call me at [redacted] to make arrangements. We apologize for any inconvenience.

The State of California requires this notice to include the following language:

If you want further information, you may contact the local state Information and Assistance Office by calling SJO 408-277-1293 or you may receive recorded information by calling 1-800-736-7401.

You may also consult an attorney of your choice. Should you decide to be represented by an attorney, you may or may not receive a larger award, but, unless you are determined to be ineligible for an award, the attorney's fee will be deducted from any award you might receive for disability benefits. The decision to be represented by an attorney is yours to make, but it is voluntary and may not be

necessary for you to receive your benefits. With or without an attorney, You may ask to have your case heard by the Workers' Compensation Appeals Board.

Sincerely,

[redacted]
Sr. Claims Examiner

Enc: PD Fact Sheet
QME election form

cc: Santa Clara VTA

/ba

ESIS, Inc.
P.O. Box 5025
Fremont, CA 94537

510.790.4600 tel
510.790.4610 fax

www.esis.com

esis

April 04, 2006

RECEIVED
VTA Risk Management

APR 1 1 2006

By

CASSIDY;SAMUEL
1178 ANGMAR CT.
SAN JOSE CA 95121

Employer's Name: SANTA CLARA VTA
Date of Injury: 05/19/2005
Claim Number: 94516350020174

Dear Mr. Cassidy:

Dr. [redacted] indicates that you are permanent and stationary and have permanent limitations from your injury. You may be entitled to additional payments. We will be sending you a letter explaining your permanent disability benefits. In accordance with Labor Code 4062, "if an employee or employer objects to a medical determination by the treating physician concerning any medical issue, written objection must be made within 20 days." If you disagree with our decision you have the right under LC 4062.1 to obtain an examination with a Qualified Medical Examiner (QME). The enclosed forms should be completed and sent to the Division of Worker's Compensation within the next 10 days.

Within 10 days of the issuance of this panel of QME's you must schedule the appointment and inform ESIS of the date of the appointment. If you do not notify us of the selection or date of the appointment within 10 days of the assignment of the panel of QME's then we will choose a physician from the panel list and schedule an appointment for you. Once an appointment has been made we will furnish you with a check for estimated travel expense to/from your appointment.

If you have any questions about the information in this letter and are not represented by an attorney, please feel free to call me at [redacted]. If you want further information you may contact the local State Information and Assistance Office by calling (408) 277-1293 , or you may receive recorded information by calling (800) 736-7401.

You may also consult an attorney of your choice. Should you decide to be represented by an attorney, you may or may not receive a larger award, but, unless you are determined to be ineligible for an award, the attorney fee will be deducted from any award you might receive for disability benefits. The decision to be represented by an attorney is yours to make, but it is voluntary and may not be necessary for you to receive your benefits. (Mandatory language per Rules & Regs 9812(g))

Sincerely,

[redacted]
SR. CLAIMS REP

Enclosures:
QME
Specialties
cc: Santa Clara VTA

STATE OF CALIFORNIA

INDUSTRIAL MEDICAL COUNCIL

Request for Qualified Medical Evaluator

IMC FORM 106

(Please Complete Form/Type or Print)

EMPLOYEE INFORMATION

TODAY'S DATE	DATE OF INJURY (LIST ONLY ONE) (Requests without month/day/year of injury will be returned)

NAME _____

ADDRESS _____

CITY, STATE, ZIP CODE _____

(AREA CODE) PHONE# _____

If currently residing out of state, list residence at the time of injury:

CITY, STATE, ZIP CODE _____

EMPLOYER INFORMATION

NAME _____

ADDRESS _____

CITY, STATE, ZIP CODE _____

(AREA CODE) PHONE# [redacted] _____

INSURER or CLAIMS ADMINISTRATOR INFORMATION

NAME _____

COMPANY _____

ADDRESS _____

CITY, STATE, ZIP CODE _____

(AREA CODE) PHONE# _____ CLAIM NUMBER _____

This Section to be Filled out by the Injured Worker ONLY

Please list ONLY ONE specialty (Insert three letter code from the back of this form)

Specialty Physician Requested: _____ _____

Signature of Injured Worker

PLEASE NOTE: Panels will be issued in the area of the injured worker's residence. If the injured worker resides out of the state the panel will be issued in the area of residence at time of injury. If due to special circumstances another city is required please attach letter of agreement from the carrier and the city and zip code being requested.

If the IMC does not issue a panel within 15 working days after this request is received by the IMC, you are entitled to select a QME of your choice. Send this completed form to:

INDUSTRIAL MEDICAL COUNCIL
Attn: DWC - Medical Unit
P.O. Box 420603
San Francisco, CA 94142
(510) 286-3700 or (800) 794-6900

IMC Form 106
Rev. 4/14/00

For Use with the QME Panel Request Form

MD/DO SPECIALTY CODES

MAI	Allergy and Immunology
MAA	Anesthesiology
MRS	Colon & Rectal Surgery
MDE	Dermatology
MEM	Emergency Medicine
MFP	Family Practice - MD
OFP	Family Practice - DO
OFM	Family Practice - DO - Including Osteopathic Manipulation
MPM	General Preventive Medicine
MOH	Hand - Orthopaedic Surgery
MPH	Hand - Plastic Surgery
MSH	Hand - Surgery
MMM	Internal Medicine
MMV	Internal Medicine - Cardiovascular Disease
MME	Internal Medicine - Endocrinology Diabetes and Metabolism
MMG	Internal Medicine - Gastroenterology
MMH	Internal Medicine - Hermatology
MMI	Internal Medicine - Infectious Disease
MMO	Internal Medicine - Medical Oncology
MMN	Internal Medicine - Nephrology
MMP	Internal Medicine - Pulmonary Disease
MMR	Internal Medicine - Rheumatology
MMQ	Medicine - Otherwise Qualified
MPN	Neurology
MNS	Neurological Surgery
MNM	Nuclear Medicine
MOG	Obstetrics and Gynecology
MPO	Occupational Medicine
MOP	Ophthalmology
MOS	Orthopaedic Surgery
MOB	Orthopaedic Surgery - Including Back
MTO	Otolaryngology
MAP	Pain Management - Anesthesiology
MPP	Pain Management - Pain Medicine
MHA	Pathology
MEP	Pediatrics
MPR	Physical Medicine & Rehabilitation
MPS	Plastic Surgery
MPD	Psychiarty
MRY	Radiology
MSY	Surgery
MSG	Surgery - General Vascular
MTS	Thoracic Surgery
MPT	Toxicology - Occupational Medicine
MET	Toxicology - Emergency Medicine
MUU	Urology

NON-MD/DO SPECIALTY CODES

*denotes a doctor of chiropractic who has completed a chiropractic post-graduate specialty program

ACA	Acupuncture
DCH	Chiropractic
DCN	Chiropractic - Neurology*
DCO	Chiropractic - Orthopaedic*
DCR	Chiropractic - Radiology*
DCS	Chiropractic - Sports Medicine*
DCT	Chiropractic - Rehabilitation*
DEN	Dentistry
OPT	Optometry
POD	Podiatry
PSY	Psychology
PSN	Psychology - Clinical Neuropsychology

ESIS, Inc.
P.O. Box 5025
Fremont, CA 94537

510.790.4600 tel
510.790.4610 fax

www.esis.com

esis

April 04, 2006

CASSIDY;SAMUEL
1178 ANGMAR CT.
SAN JOSE CA 95121

Employer's Name: SANTA CLARA VTA
Date of Injury: 05/19/2005
Claim Number: 94516350020174

Dear Mr. Cassidy:

Dr. [redacted] indicates that you are permanent and stationary and have permanent limitations from your injury. You may be entitled to additional payments. We will be sending you a letter explaining your permanent disability benefits. In accordance with Labor Code 4062, "if an employee or employer objects to a medical determination by the treating physician concerning any medical issue, written objection must be made within 20 days." If you disagree with our decision you have the right under LC 4062.1 to obtain an examination with a Qualified Medical Examiner (QME). The enclosed forms should be completed and sent to the Division of Worker's Compensation within the next 10 days.

Within 10 days of the issuance of this panel of QME's you must schedule the appointment and inform ESIS of the date of the appointment. If you do not notify us of the selection or date of the appointment within 10 days of the assignment of the panel of QME's then we will choose a physician from the panel list and schedule an appointment for you. Once an appointment has been made we will furnish you with a check for estimated travel expense to/from your appointment.

If you have any questions about the information in this letter and are not represented by an attorney, please feel free to call me at [redacted]. If you want further information you may contact the local State Information and Assistance Office by calling (408) 277-1293, or you may receive recorded information by calling (800) 736-7401.

You may also consult an attorney of your choice. Should you decide to be represented by an attorney, you may or may not receive a larger award, but, unless you are determined to be ineligible for an award, the attorney fee will be deducted from any award you might receive for disability benefits. The decision to be represented by an attorney is yours to make, but it is voluntary and may not be necessary for you to receive your benefits. (Mandatory language per Rules & Regs 9812(g))

Sincerely,

[redacted]
SR. CLAIMS REP

Enclosures:
QME
Specialties
cc: Santa Clara VTA

STATE OF CALIFORNIA — ARNOLD SCHWARZENEGGER, Governor

DEPARTMENT OF INDUSTRIAL RELATIONS
DIVISION OF WORKERS' COMPENSATION
MEDICAL UNIT
1515 Clay Street, 18th Floor
Oakland, CA 94612
Tel. No.: (510) 286-3700 or 1-(800) 794-6900

HOW TO REQUEST A QUALIFIED MEDICAL EVALUATOR

IF YOU DO NOT HAVE A LAWYER

Since you do not have a lawyer, you may ask the Division of Workers' Compensation (DWC) Medical Unit for help in getting a Qualified Medical Evaluator (QME). The QME will look at your injury and answer medical questions about it.

To ask for a QME, please fill out the attached form and return immediately. You may ask for help from your treating doctor to determine the specialty appropriate for your injury. If the request form is incomplete or improperly completed, the form will be returned to you to correct the problem.

After our office processes your request, you will receive, in the mail, a list of three QMEs. These QMEs are selected at random and should have an office close to you. Only you may select the specialty of the QME who performs the evaluation.

You must make your appointment with one of the QMEs on the list. If the QME cannot make an appointment for an evaluation within 60 days of your call, you may either wait to see that QME of your choice or you may call us to get a replacement QME for your list. After completing the evaluation, the QME must send you a report within:

(a) 30 days of your appointment - if date of injury is on or after 1/1/94 or,
(b) 45 days of your appointment - if date of injury is between 1/1/91 and 12/31/93.

Please call DWC Medical Unit at 1-800-794-6900, or the Information and Assistance officer from the Division of Workers' Compensation at 1-800-736-7401, if you have any questions relating to your workers' compensation claim.

Attachment to: Form 106
Form 105, Rev. 4/14/00

CASSIDY;SAMUEL 94516350020174 883 884

STATE OF CALIFORNIA

INDUSTRIAL MEDICAL COUNCIL

Request for Qualified Medical Evaluator

IMC FORM 106

(Please Complete Form/Type or Print)

EMPLOYEE INFORMATION

TODAY'S DATE	DATE OF INJURY (LIST ONLY ONE) (Requests without month/day/year of injury will be returned)
04/04/2006	05/19/2005

NAME **CASSIDY;SAMUEL**

ADDRESS 1178 ANGMAR CT.

CITY, STATE, ZIP CODE SAN JOSE CA 95121

(AREA CODE) PHONE#

If currently residing out of state, list residence at the time of injury:

CITY, STATE, ZIP CODE

EMPLOYER INFORMATION

NAME SANTA CLARA VTA

ADDRESS SANTA CLARA VTA - 52210 LIGHT

CITY, STATE, ZIP CODE

(AREA CODE) PHONE# (408) 546-7670

INSURER or CLAIMS ADMINISTRATOR INFORMATION

NAME [redacted]

COMPANY ESIS

ADDRESS [redacted]

CITY, STATE, ZIP CODE [redacted]

(AREA CODE) PHONE# [redacted] CLAIM NUMBER **94516350020174**

This Section to be Filled out by the Injured Worker ONLY

Please list ONLY ONE specialty (Insert three letter code from the back of this form)

Specialty Physician Requested:

Signature of Injured Worker

PLEASE NOTE: Panels will be issued in the area of the injured worker's residence. If the injured worker resides out of the state the panel will be issued in the area of residence at time of injury. If due to special circumstances another city is required please attach letter of agreement from the carrier and the city and zip code being requested.

If the IMC does not issue a panel within 15 working days after this request is received by the IMC, you are entitled to select a QME of your choice. Send this completed form to:

INDUSTRIAL MEDICAL COUNCIL
Attn: DWC - Medical Unit
P.O. Box 420603
San Francisco, CA 94142
(510) 286-3700 or (800) 794-6900

IMC Form 106
Rev. 4/14/00

For Use with the QME Panel Request Form

MD/DO SPECIALTY CODES

MAI	Allergy and Immunology
MAA	Anesthesiology
MRS	Colon & Rectal Surgery
MDE	Dermatology
MEM	Emergency Medicine
MFP	Family Practice - MD
OFP	Family Practice - DO
OFM	Family Practice - DO - Including Osteopathic Manipulation
MPM	General Preventive Medicine
MOH	Hand - Orthopaedic Surgery
MPH	Hand - Plastic Surgery
MSH	Hand - Surgery
MMM	Internal Medicine
MMV	Internal Medicine - Cardiovascular Disease
MME	Internal Medicine - Endocrinology Diabetes and Metabolism
MMG	Internal Medicine - Gastroenterology
MMH	Internal Medicine - Hermatology
MMI	Internal Medicine - Infectious Disease
MMO	Internal Medicine - Medical Oncology
MMN	Internal Medicine - Nephrology
MMP	Internal Medicine - Pulmonary Disease
MMR	Internal Medicine - Rheumatology
MMQ	Medicine - Otherwise Qualified
MPN	Neurology
MNS	Neurological Surgery
MNM	Nuclear Medicine
MOG	Obstetrics and Gynecology
MPO	Occupational Medicine
MOP	Ophthalmology
MOS	Orthopaedic Surgery
MOB	Orthopaedic Surgery - Including Back
MTO	Otolaryngology
MAP	Pain Management - Anesthesiology
MPP	Pain Management - Pain Medicine
MHA	Pathology
MEP	Pediatrics
MPR	Physical Medicine & Rehabilitation
MPS	Plastic Surgery
MPD	Psychiarty
MRY	Radiology
MSY	Surgery
MSG	Surgery - General Vascular
MTS	Thoracic Surgery
MPT	Toxicology - Occupational Medicine
MET	Toxicology - Emergency Medicine
MUU	Urology

NON-MD/DO SPECIALTY CODES

*denotes a doctor of chiropractic who has completed a chiropractic post-graduate specialty program

ACA	Acupuncture
DCH	Chiropractic
DCN	Chiropractic - Neurology*
DCO	Chiropractic - Orthopaedic*
DCR	Chiropractic - Radiology*
DCS	Chiropractic - Sports Medicine*
DCT	Chiropractic - Rehabilitation*
DEN	Dentistry
OPT	Optometry
POD	Podiatry
PSY	Psychology
PSN	Psychology - Clinical Neuropsychology

esis

ESIS
ESIS
39300 Civic Center Drive
Suite 300
Fremont, CA 94536
USA

510.790.8741 *tel*
800.335.3418 *fax*
[redacted]
www.esis.com

[redacted]

February 22, 2007

Workers' Compensation Appeals Board
100 Paseo de San Antonio, Suite 241
San Jose, Ca 95113

RE:

WCAB #:	
Applicant:	Samuel Cassidy
Employer:	Santa Clara VTA
D/Injury:	05/19/05
Claim #:	9451 635 0020174

Dear Workers' Compensation Judge:

Due to the fact ESIS has gone paperless effective 4/01/06; we are unable to provide original documents. Therefore, enclosed are signed copies of Stipulations with Request for rewards for your review and kind approval.

Please find enclosed the following correspondence for your review and consideration:

- Signed Stipulations with Request For Award
- DEU Rating
- Medical Records
- Benefit Notices

If you have any questions or concerns, please feel free to contact me at the address listed above.

Respectfully yours,

[redacted]
Sr. Claims Examiner

Enclosures:

Cc: Santa Clara VTA 3331 N First Street San Jose, Ca 95134
Samuel Cassidy 1178 Angmar Court San Jose, Ca 95121

esis

ESIS / ACE USA
P.O. Box 31083
Tampa, FL 33631-3083

PROOF OF SERVICE BY MAIL

I declare that: [redacted]

I am employed in the County of Alameda, California.

I am over the age of eighteen years and an employee of ESIS / ACE USA, who is a party to this action, and I have no personal interest in this matter; my business address is 39300 Civic Center Drive, Suite 300, Fremont, California, 94538. On 02/22/07 I served the above-mentioned signed stipulation with request for award, copy of DEU rating, medical records and benefit notices on the parties in said cause by placing a true copy thereof enclosed in a sealed envelope with postage thereon fully prepaid, in the United States mail at Fremont, California, addressed as follows:

Workers' Compensation Appeals Board
100 Paseo de San Antonio, Suite 241
San Jose, Ca 95113

I declare under penalty of perjury that the foregoing is true and correct and that this declaration was executed on 02/22/07, at Fremont, California.

[redacted]

ESIS/ACE USA

File No.: 9451 635 0020174

STATE OF CALIFORNIA
DIVISION OF WORKERS' COMPENSATION
WORKERS' COMPENSATION APPEALS BOARD

STIPULATIONS WITH REQUEST FOR AWARD

Case No(s). _____

Social Security No. [redacted]

CASSIDY;SAMUEL (9451-635-0020174) — 1178 ANGMAR CT, SAN JOSE, CA 95121
Applicant (Employee) — Address

SANTA CLARA VTA — 3331 NORTH FIRST ST, SAN JOSE, CA 951231
Correct Name(s) of Employer(s) — Address(es)

ESIS COMPANIES — P.O. BOX 31083, TAMPA, FL 33631
Correct Name(s) of Insurance Carrier(s) Claims Administrator(s) — Address(es)

The parties hereto stipulate to the issuance of an Award and/or Order, based upon the following facts, and waive the requirements of Labor Code Section 5313:

1. SAMUEL CASSIDY (employee), born 8-29-63 (date), while employed at SANTA CLARA VTA

SDAN JOSE (city), CA (state) as a(n) ELECTRIC MECHANIC (occupation), _____ (group)

on 5-19-05 (date[s] of injury(ies))

by SANTA CLARA VTA (employer(s)) whose compensation insurance carrier(s) was/were

ESIS COMPANIES sustained injury(ies) arising out of and in the

course of employment to LEFT KNEE (parts of body injured).

2. The injury(ies) caused temporary disability for the period(s) 11-17-05 through 12-20-05 for which indemnity has been paid at $ 840.00 per week. 2(a). The injury(ies) caused additional temporary disability for the period _____ through _____ at the rate of $_____ in the amount of $_____.

3. The injury(ies) caused permanent disability of 3%, for which indemnity is payable at $ 220.00 per week beginning 12-20-05, in the sum of $ 1980.00, less credit for such payments previously made. ☐ And a life pension of _____ per week thereafter.

Labor Code §4658(d) adjustment: ☐ Increase rate to _____ as of _____. ☐ Decrease rate to _____ as of _____.

☐ Not applicable.

An informal rating has/has not (select one) been previously issued. DEU # INDEPENDENT RATING

Applicant/Employee: SAMUEL CASSIDY WCAB No(s). _____

4. There [X] is [ ] need for medical treatment to cure or relieve from the effects of said injury(ies).

5. Medical-legal expenses and/or liens are payable by defendant as follows:

N/A

6. Applicant's attorney requests a fee of $ N/A [ ] Fees to be commuted as follows: _____.

7. Liens against compensation are payable as follows:

8. Any accrued claims for Labor Code Section 5814 penalties are included in this settlement unless expressly excluded.

9. Other stipulations:

There has been an overpayment in temporary disability benefits of $1200.00 therefore we have credited this amount against permanent disability.

12/7/06
Dated

Samuel Cassidy
SAMUEL CASSIDY
Applicant

[redacted]
Attorney or Authorized Representative for Defendant

N/A [redacted] 33631-3083
Address of Attorney or Authorized Representative

NONE
Attorney or Authorized Representative for Applicant

NONE
Address of Attorney or Authorized Representative

NONE
Interpreter

Applicant/Employee: SAMUEL CASSIDY WCAB No(s). _____

AWARD

AWARD IS MADE in favor of SAMUEL CASSIDY against

SANTA CLARA VTA of:
(entity legally obligated to pay the award)

(A) Additional temporary disability indemnity in accordance with paragraph 2(a) above,

(B) Permanent disability indemnity in accordance with paragraph 3 above,

Less the sum of $ NONE, payable to applicant's attorney as the reasonable value of services rendered.

☐ Fees are to be commuted pursuant to Paragraph 6.

(C) Liens in accordance with Paragraph 7 above,

(D) Further medical treatment in accordance with Paragraph 4 above,

(E) Reimbursement for medical-legal expenses in accordance with Paragraph 5 above,

(F) Stipulations in Paragraph 8 and 9 are approved.

(G) The matter is ordered off calendar / set for status/lien conference.

(H)

_____
(Dated)

_____
WORKERS' COMPENSATION ADMINISTRATIVE LAW JUDGE
WORKERS' COMPENSATION APPEALS BOARD

On _____, this document ☐was personally served on all persons appearing at the hearing on said date, as set forth in the minutes of that hearing ☐was personally served on

_____
_____
_____
_____

☐was served by mail on all persons listed on the Official Address Record ☐was served by mail on following party or parties: _____
_____
_____
_____

By _____

☐NOTICE TO: _____
Pursuant to Rule 10500, you are designated to serve this document on all parties shown on the Official Address Record, together with a proof of service. You shall maintain this proof of service, which shall not be filed with the WCAB unless a dispute arises regarding service. A copy of the current Official Address Record accompanies this notice.

STATE OF CALIFORNIA
DIVISION OF WORKERS' COMPENSATION
WORKERS' COMPENSATION APPEALS BOARD

STIPULATIONS WITH REQUEST FOR AWARD

533

Case No(s). SJO-0262685

Social Security No. [redacted]

CASSIDY,SAMUEL (945-63-5-0020174) — Applicant (Employee)
1178 ANGMAR CT, SAN JOSE, CA 95121 — Address

SANTA CLARA VTA — Correct Name(s) of Employer(s)
3331 NORTH FIRST ST, SAN JOSE, CA 951231 — Address(es)

ESIS COMPANIES — Correct Name(s) of Insurance Carrier(s) Claims Administrator(s)
P.O. BOX 31083, TAMPA, FL 33631 — Address(es)

The parties hereto stipulate to the issuance of an Award and/or Order, based upon the following facts, and waive the requirements of Labor Code Section 5313:

1. SAMUEL CASSIDY (employee), born 8-29-63 (date), while employed at SANTA CLARA VTA (employer(s)) SDAN JOSE (city), CA (state) as a(n) ELECTRIC MECHANIC (occupation), _____ (group) on 5-19-05 (date[s] of injury[ies]) by SANTA CLARA VTA whose compensation insurance carrier(s) was/were ESIS COMPANIES sustained injury(ies) arising out of and in the course of employment to LEFT KNEE (parts of body injured).

2. ~~The injury(ies) caused temporary disability for the period(s)~~ 11-17-05 through 12-28-05 for which indemnity has been paid at $ 840.00 per week. 2(a). The injury(ies) caused additional temporary disability for the period _____ through _____ at the rate of $_____ in the amount of $_____.

3. The injury(ies) caused permanent disability of 3% %, for which indemnity is payable at $ 220.00 per week beginning 12-20-05, in the sum of $ 1980.00, less credit for such payments previously made. ☐ And a life pension of _____ per week thereafter.

Labor Code §4658(d) adjustment: ☐ Increase rate to _____ as of _____. ☐ Decrease rate to _____ as of _____.

☐ Not applicable.

An Informal rating ~~letter~~/has not (select one) been previously issued. DEU # INDEPENDENT RATING

Applicant/Employee: SAMUEL CASSIDY WCAB No(s).

4. There [X] is [ ] ~~is~~ need for medical treatment to cure or relieve from the effects of said injury(ies).

5. Medical-legal expenses and/or liens are payable by defendant as follows:

N/A

6. Applicant's attorney requests a fee of $ N/A [ ] Fees to be commuted as follows:

7. Liens against compensation are payable as follows:

8. Any accrued claims for Labor Code Section 5814 penalties are included in this settlement unless expressly excluded.

9. Other stipulations:

There has been an overpayment in temporary disability benefits of $1200.00 therefore we have credited this amount against permanent disability.

12/7/06
Dated

Samuel Cassidy
SAMUEL CASSIDY
Applicant

NONE
Attorney or Authorized Representative for Applicant

NONE
Address of Attorney or Authorized Representative

NONE
Interpreter

[redacted]
Attorney or Authorized Representative for Defendant

N/A [redacted]
Address of Attorney or Authorized Representative

03/05/2007 3007064T5265011

01[illegible]007 3007026T5149041

Applicant/Employee: SAMUEL CASSIDY WCAB No(s). STC 626 85

AWARD

AWARD IS MADE in favor of SAMUEL CASSIDY against

SANTA CLARA VTA of:

(entity legally obligated to pay the award)

(A) Additional temporary disability indemnity in accordance with paragraph 2(a) above,

(B) Permanent disability indemnity in accordance with paragraph 3 above.

Less the sum of $ NONE, payable to applicant's attorney as the reasonable value of services rendered.

☐ Fees are to be commuted pursuant to Paragraph 6.

(C) Liens in accordance with Paragraph 7 above,

(D) Further medical treatment in accordance with Paragraph 4 above,

(E) Reimbursement for medical-legal expenses in accordance with Paragraph 5 above,

(F) Stipulations in Paragraph 8 and 9 are approved.

(G) The matter is ordered off calendar / set for status/lien conference.

(H)

2/28/07

(Dated)

WORKERS' COMPENSATION ADMINISTRATIVE LAW JUDGE
WORKERS' COMPENSATION APPEALS BOARD

On 2/28/07, this document ☐was personally served on all persons appearing at the hearing on said date, as set forth in the minutes of that hearing ☐was personally served on

☐was served by mail on all persons listed on the Official Address Record ☐was served by mail on following party or parties:

By [redacted]

☐NOTICE TO:

Pursuant to Rule 10500, you are designated to serve this document on all parties shown on the Official Address Record, together with a proof of service. You shall maintain this proof of service, which shall not be filed with the WCAB unless a dispute arises regarding service. A copy of the current Official Address Record accompanies this notice.

SANTA CLARA **Valley Transportation Authority**

This Incident/Injury/Illness is reported as (please circle one): NEW RECURRENCE INCIDENT ONLY (no injury)

Guadalupe

OCCUPATIONAL INCIDENT, INJURY OR ILLNESS INVESTIGATION REPORT

COMPLETE WITHIN 24-HOURS OF NOTIFICATION OF THE INCIDENT
A medical evaluation is required for ALL New or Recurring injuries/illnesses.

Division / Facility / Department: D-6
[redacted] Supervisor's Name: [redacted]

Employee's Name: Samuel Cassidy
Badge Number: 10391
Incident Date: 10/2/2010

Line Out Days Off and Circle Day of Incident: ~~M~~ T W Th F (Sat) ~~Sun~~
Incident Time: 3:30pm
Date Reported: 10/2/2010

Work Hours: 10:00Am-6:30pm
On Regular Time, Overtime, Off Duty? Regular
Amount of time lost (hours : minutes): 3:00
Accident hour(s) and minute(s) into shift: ~~Good~~ 5:30

Exact Location: Guadalupe
Weather Conditions: in Doors
Light Conditions: Good

Vehicle / Coach Number: DNA
Line / Route Number: DNA
Block Number: DNA

Street and nearest cross street: Younger-San Pedro
Was there third party involvement: NO
Name of 3rd party: DNA

Was a Defect Card completed? N/A ☒ NO ☐ YES ☐

Follow Up Investigation Conducted by: [redacted]
Date: 10/2/2010

Please describe the task being performed when the incident/injury/illness occurred: Injured was Holding tools including Razor blade Scraper

Please describe the nature (body part effected) of the injury/illness, be as specific as possible: ONE inch Cut on Left wrist

Was employee sent for medical care? N/A ___ NO ___ YES* X

*If yes Provide the following: O'Conner Hospital ~~suite 200~~

Medical facility's address: ~~1892 Monterey Rd~~ SJ, CA 95112 Medical facility's Phone Number ___

Was first aid (e.g., bandage) offered? N/A ___ NO ___ YES** X

**If yes, what kind of first aid was provided? San Jose Fire Engine-5 AMR 725

Following the employee interview, describe exactly how the incident, illness, or injury occurred. Provide the key, triggering event and include any contributing factors such as, but not limited to, loose gravel, trip hazard.

Injured was holding tools, ONE fell from his hand. He bent over to pick it up when Razor ~~cut his wrist.~~ blade Scraper Accidently pressed up AGAINST his wrist.

Considering all factors reported and observed, what is the probable root cause (s) of the incident?

How is the claimed injury consistent with all factors reported and observed at the scene? Consistant.

Provide a summary of any eye-witness accounts (include the names and phone numbers of any witnesses): NO Eye-witness

OCCUPATIONAL ACCIDENT, INJURY OR ILLNESS INVESTIGATION REPORT

VTA IIPP Procedure FRS-RM-0302 Industrial Accident Investigation – page 2 of 2

What steps were taken to verify the employee statement? _____

Was the data pack pulled? N/A ☒ NO ☐ YES ☐

What specific training has the employee received to prevent this type of incident? NONE

What repairs and/or corrective actions are required to ensure that this type of incident does not recur? When will the corrective actions be completed? (Please provide estimated completion dates) NONE

If property damage occurred, please describe and list who is responsible for completing repair(s) and/or implementing corrective action(s)? NONE

Name / Division	Contact was made via:

The following forms have been completed and sent to TRISTAR and Risk Management on the dates indicated.

DWC-1	Form 5020	Form 302 (this form)
faxed on: 10/2/10	faxed on: 10/2/10	faxed on: 10/2/10

Additional Investigator comments: _____

[redacted] 10/2/10

Follow-Up Investigator Signature — Date Signed

Department Supervisor comments: _____

Signature of the Department Supervisor — Date Signed

Division Superintendent comments: _____

Signature of the Division Superintendent — Date Signed

Employee's Name:	Badge Number:	Incident Date

Distribution: original – Risk Management
copy – employee's division Industrial Injury file (retain copy for 1 year) rev. 02/2008

State of California
EMPLOYER'S REPORT OF OCCUPATIONAL INJURY OR ILLNESS

Please comp[illegible] triplicate (type if possible) Mail two copies to:
TRISTAR [illegible] Management
P.O.Box 9350
Walnut Creek, CA 94598 1 888-339-8822 FAX 925-930-0674

OSHA CASE NO.

FATALITY ☐

Any person who makes or causes to be made any knowingly false or fraudulent material statement or material representation for the purpose of obtaining or denying workers compensation benefits or payments is guilty of a felony.

California law requires employers to report within five days of knowledge every occupational injury or illness which results in lost time beyond the date of the incident OR requires medical treatment beyond first aid. If an employee subsequently dies as a result of a previously reported injury or illness, the employer must file within five days of knowledge an amended report indicating death. In addition, every serious injury, illness, or death must be reported immediately by telephone or telegraph to the nearest office of the California Division of Occupational Safety and Health.

EMPLOYER

1. FIRM NAME: Santa Clara Valley Transportation Authority
1a. Policy Number
Please do not use this column
2. MAILING ADDRESS: (Number, Street, City, Zip): 3331 North First Street, San Jose, CA 95134
2a. Phone Number
CASE NUMBER
3. LOCATION if different from Mailing Address (Number, Street, City and Zip)
3a.Cost Center: 52210
OWNERSHIP
4. NATURE OF BUSINESS; e.g., Painting contractor, wholesale grocer, sawmill, hotel, etc.: Transportation
5. State unemployment insurance acct. no.: 92500461
INDUSTRY
6. TYPE OF EMPLOYER: ☐ Private ☐ State ☐ County ☐ City ☐ School District ☒ Other Gov't, Specify: Special District

INJURY OR ILLNESS

7. DATE OF INJURY / ONSET OF ILLNESS (mm/dd/yy): 10/2/2010
8. TIME INJURY/ILLNESS OCCURRED: ___ AM 3:30 PM
9. TIME EMPLOYEE BEGAN WORK: 10:00 AM ___ PM
10. IF EMPLOYEE DIED, DATE OF DEATH (mm/dd/yy)
OCCUPATION
11. UNABLE TO WORK FOR AT LEAST ONE FULL DAY AFTER DATE OF INJURY? ☐ Yes ☐ No
12. DATE LAST WORKED (mm/dd/yy): 10/2/2010
13. DATE RETURNED TO WORK (mm/dd/yy)
14. IF STILL OFF WORK, CHECK THIS BOX: ☐
15. PAID FULL DAY'S WAGES FOR DATE OF INJURY OR LAST DAY WORKED? ☒ Yes ☐ No
16. SALARY BEING CONTINUED? ☒ Yes ☐ No
17. DATE OF EMPLOYER'S KNOWLEDGE /NOTICE OF INJURY/ILLNESS (mm/dd/yy): 10/2/2010
18. DATE EMPLOYEE WAS PROVIDED CLAIM FORM (mm/dd/yy): 10/2/2010
SEX
19. SPECIFIC INJURY/ILLNESS AND PART OF BODY AFFECTED, MEDICAL DIAGNOSIS if available, e.g., Second degree burns on right arm, tendonitis on left elbow, lead poisoning: Cut on Left wrist
AGE
20. LOCATION WHERE EVENT OR EXPOSURE OCCURRED (Number, Street, City, Zip): 101 W. Younger St. San Jose, CA 95110
20a. COUNTY: Santa Clara
21. ON EMPLOYER'S PREMISES? ☒ Yes ☐ No
DAILY HOURS
22. DEPARTMENT WHERE EVENT OR EXPOSURE OCCURRED, e.g., Shipping department, machine shop.: Transportation Maintance Shop
23. Other Workers Injured/Ill in this event? ☐ Yes ☒ No
DAYS PER WEEK
24. EQUIPMENT, MATERIALS AND CHEMICALS THE EMPLOYEE WAS USING WHEN EVENT OR EXPOSURE OCCURRED, e.g., Acetylene, welding torch, farm tractor, scaffold: Razor Blade Scraper
WEEKLY HOURS
25. SPECIFIC ACTIVITY THE EMPLOYEE WAS PERFORMING WHEN EVENT OR EXPOSURE OCCURRED, e.g., Welding seams of metal forms, loading boxes onto truck.: Walking with Tools in His Hand
WEEKLY WAGE
26. HOW INJURY/ILLNESS OCCURRED. DESCRIBE SEQUENCE OF EVENTS. SPECIFY OBJECT OR EXPOSURE WHICH DIRECTLY PRODUCED THE INJURY/ILLNESS, e.g., Worker stepped back to inspect work and slipped on scrap metal. As he fell, he brushed against fresh weld, and burned right hand. USE SEPARATE SHEET IF NECESSARY: Worker was walking with tools in his Hand
26b. Why in your opinion did this accident/exposure occur? (list causes): Accident
COUNTY
26c. What have you done to prevent a similar injury/illness?: Carry Less tools
27. NAME AND ADDRESS OF PHYSICIAN (Number, Street, City, Zip)
27a. Phone Number
NATURE OF INJURY
28. HOSPITALIZED AS AN INPATIENT OVERNIGHT? ☐ Yes ☐ No If yes, NAME AND ADDRESS OF HOSPITAL (Number, Street, City, Zip)
28a. Phone Number
PART OF BODY
29. Employee treated in Emergency Room? ☐ Yes ☐ No

ATTENTION: This form contains information relating to employee health and must be used in a manner that protects the confidentiality of employees to the extent possible while the information is being used for occupational safety and health purposes. See CCR Title 8 14300.29 (b)(6)-(10) & 14300.35(b)(2)(E)2.
Note: Shaded boxes indicate confidential employee information as listed in CCR Title 8 14300.35(b)(2)(E)2.*
SOURCE

EMPLOYEE

30. EMPLOYEE NAME: Cassidy, Samuel
31. SOCIAL SECURITY NUMBER
32. DATE OF BIRTH (mm/dd/yy)
EVENT
33. HOME ADDRESS (Number, Street, City, Zip)
33a. PHONE NUMBER
SECONDARY SOURCE
34. SEX: ☐ Male ☒ Female
35. OCCUPATION (Regular job title, NO initials, abbreviations or numbers): Electro Mechanic
UNION AFFILIATION: ATU
36. DATE OF HIRE (mm/dd/yy)
37. EMPLOYEE USUALLY WORKS: 5 hours per day 5 days per week, 40 total weekly hours
37a. EMPLOYMENT STATUS: ☒ regular, full time ☐ part-time ☐ temporary ☐ Seasonal
37b. UNDER WHAT CLASS CODE OF YOUR POLICY WERE WAGES ASSIGNED?
EXTENT OF INJURY
38. GROSS WAGES/SALARY year: $37.06/hr
39. OTHER PAYMENTS NOT REPORTED AS WAGES/SALARY (e.g. tips, meals, overtime, bonuses, etc.)?

Completed By (type or print): [redacted]
Signature & Title: [redacted] Transportation Supervisor
Date (mm/dd/yy)

*Confidential information may be disclosed only to the employee, former employee, or their personal representative (CCR Title 8 14300.35), to others for the purpose of processing a workers' compensation or other insurance claim; and under certain circumstances to a public health or law enforcement agency or to a consultant hired by the employer (CCR Title 8 14300.30). CCR Title 8 14300.40 requires provision upon request to certain state and federal workplace safety agencies.

FORM 5020 (Rev7) June 2002

FILING OF THIS FORM IS NOT AN ADMISSION OF LIABILITY

[redacted] 408-629-6522
Samuel Cassidy
DOH - 1/22/2001 DOB - 8/29/1963
Address on file - 1178 Angmer Ct San Jose, CA 95121

State of California
Department of Industrial Relations
DIVISION OF WORKERS' COMPENSATION

Estado de California
Departamento de Relaciones Industriales
DIVISION DE COMPENSACIÓN AL TRABAJADOR

WORKERS' COMPENSATION CLAIM FORM (DWC 1)

PETITION DEL EMPLEADO PARA DE COMPENSACIÓN DEL TRABAJADOR (DWC 1)

Employee: Complete the "Employee" section and give the form to your employer. Keep a copy and mark it "Employee's Temporary Receipt" until you receive the signed and dated copy from your employer. You may call the Division of Workers' Compensation and hear recorded information at (800) 736-7401. An explanation of workers' compensation benefits is included as the cover sheet of this form.

You should also have received a pamphlet from your employer describing workers' compensation benefits and the procedures to obtain them.

Any person who makes or causes to be made any knowingly false or fraudulent material statement or material representation for the purpose of obtaining or denying workers' compensation benefits or payments is guilty of a felony.

Empleado: *Complete la sección "Empleado" y entregue la forma a su empleador. Quédese con la copia designada "Recibo Temporal del Empleado" hasta que Ud. reciba la copia firmada y fechada de su empleador. Ud. puede llamar a la Division de Compensación al Trabajador al (800) 736-7401 para oir información gravada. En la hoja cubierta de esta forma esta la explicatión de los beneficios de compensación al trabjador.*

Ud. también debería haber recibido de su empleador un folleto describiendo los benficios de compensación al trabajador lesionado y los procedimientos para obtenerlos.

Toda aquella persona que a proposito haga o cause que se produzca cualquier declaracion o representacion material falsa o fraudulenta con el fin de obtener o negar beneficios o pagos de compensación a trabajadores lesionados es culpable de un crimen mayor "felonia".

Employee—complete this section and see note above. ***Empleado—complete esta sección y note la notación arriba.***

1. Name. *Nombre.* Sam Cassidy — Today's Date. *Fecha de Hoy.* 10/2/10
2. Home Address. *Dirección Residencial.* 1178 Ardmar Court
3. City. *Ciudad.* San Jose — State. *Estado.* CA — Zip. *Código Postal.* 95121
4. Date of Injury. *Fecha de la lesión (accidente).* 10/2/10 — Time of Injury. *Hora en que ocurrió.* ____ a.m. 3:30 p.m.
5. Address and description of where injury happened. *Dirección/lugar dónde occurió el accidente.* 101 West Younger Ave
6. Describe injury and part of body affected. *Describa la lesión y parte del cuerpo afectada.* Lt wrist + CVA
7. Social Security Number. *Número de Seguro Social del Empleado.* [redacted]
8. Signature of employee. *Firma del empleado.* [signature]

Employer—complete this section and see note below. ***Empleador—complete esta sección y note la notación abajo.***

9. Name of employer. *Nombre del empleador.* Santa Clara Valley Transportation Authority
10. Address. *Dirección.*
11. Date employer first knew of injury. *Fecha en que el empleador supo por primera vez de la lesión o accidente.*
12. Date claim form was provided to employee. *Fecha en que se le entregó al empleado la petición.*
13. Date employer received claim form. *Fecha en que el empleado devolvió la petición al empleador.*
14. Name and address of insurance carrier or adjusting agency. *Nombre y dirección de la compañía de seguros o agencia adminstradora de seguros.* TRISTAR RISK MANAGEMENT P.O.Box 9350 Walnut Creek, CA 94598
15. Insurance Policy Number. *El número de la póliza de Seguro.* Permissably Self-Insured
16. Signature of employer representative. *Firma del representante del empleador.* [redacted]
17. Title. *Título.* Transportation Supervisor — 18. Telephone. *Teléfono.* [redacted]

Employer: You are required to date this form and provide copies to your insurer or claims administrator and to the employee, dependent or representative who filed the claim within one working day of receipt of the form from the employee.

Empleador: *Se requiere que Ud. feche esta forma y que provéa copias a su compañía de seguros, administrador de reclamos, o dependiente/representante de reclamos y al empleado que hayan presentado esta petición dentro del plazo de un día hábil desde el momento de haber sido recibida la forma del empleado.*

SIGNING THIS FORM IS NOT AN ADMISSION OF LIABILITY

EL FIRMAR ESTA FORMA NO SIGNIFICA ADMISION DE RESPONSABILIDAD

☐ Employer copy/*Copia del Empleador* ☐ Employee copy/ *Copia del Empleado* ☐ Claims Administrator/*Administrador de Reclamos* ☐ Temporary Receipt/*Recibo del Empleado*

7/1/04 Rev.

[redacted]

From: [redacted]
Sent: Saturday, October 02, 2010 6:12 PM
To: [redacted]
Subject: II Report for Electro Mechanic Samuel Cassidy 10391

An II report has been faxed to Tristar, Risk Management and Rail Ops for Electro Mechanic Samuel Cassidy 10391.
The hard copy is in the Supervisors in basket at Cerone building H.
He has a one inch cut on his left wrist. SJFD Engine 5 and AMR 725 responded. He was not transported; he went to O'Conner Hospital on his own.

[redacted]

[redacted]

From: [redacted]
Sent: Saturday, October 02, 2010 5:43 PM
To: [redacted]
Subject: FW: Guadalupe Employee Injury

[redacted]

FYI

From: [redacted]
Sent: Sat 10/2/2010 4:23 PM
To: Call.Out.List
Subject: FW: Guadalupe Employee Injury

FINAL UPDATE:

Per Supervisor [redacted], the mechanic was released by SJFD E-5 and AMR #725. An Industrial Injury Claim has been filed with the supervisor. The employee will be going to [redacted] for follow-up treatment to his left hand/wrist. 307 advised.

From: [redacted]
Sent: Saturday, October 02, 2010 4:02 PM
To: Call.Out.List
Subject: Guadalupe Employee Injury

1. Guadalupe Employee Injury
2. 1540 hours
3. 10 2 10
4. Guadalupe Division
5. Dna
6. 961
7. Dna
8. 10391
9. S. Cassidy
10. CCOM
11. Dna
12. #337; [redacted]
13. Per the Maintenance Foreman, a mechanic removing a decal with a razor cut his hand/wrist with it. CCOM advised. Supervisor [redacted] advised. 307 advised.
14. Cut to hand/wrist
15. Dna

More to Follow.

Regards,

[redacted]

Transportation Supervisor
OCC Rail Controller
101 W. Younger Ave. Bldg, A
San Jose CA, 95110
408-546-7688 OCC
[redacted]

Yard: Way, Power & Signal

Shift: All

Effective Date: 1/11/2021

Name	Badge #	Control #	Work Sched	Hours	Day Off	Remarks
[redacted]		WPS-PFL-1	G-MN07	10:00P - 6:30A	F/S	
		WPS-PFL-2	D-GD05	6:00A - 2:30P	F/S	
		WPS-LOW-1	D-GD01	6:00A - 2:30P	S/M	
		WPS-LOW-2	G-MN07	10:00P - 6:30A	F/S	
		WPS-LOW-3	G-MN07	10:00P - 6:30A	F/S	
		WPS-LOW-4	G-MN07	10:00P - 6:30A	F/S	
		WPS-LOW-5	G-MN07	10:00P - 6:30A	F/S	
		WPS-LOW-6	G-MN07	10:00P - 6:30A	F/S	Not to be bid until fully staffed
		WPS-LOW-7	G-MN03	10:00P - 6:30A	S/M	
		WPS-LOW-8	G-MN03	10:00P - 6:30A	S/M	
		WPS-LOW-9	G-MN03	10:00P - 6:30A	S/M	
		WPS-LOW-10	G-MN03	10:00P - 6:30A	S/M	
		WPS-LOW-11	G-MN03	10:00P - 6:30A	S/M	
		WPS-LOW-12	G-MN03	10:00P - 6:30A	S/M	Not to be bid until fully staffed
Sam Cassidy	10391	WPS-LSM-1	D-GD01	6:00A - 2:30P	S/M	Lead-WFM-Fri/Sat
[redacted]		WPS-LSM-2	D-GD01	6:00A - 2:30P	S/M	
		WPS-LSM-3	D-GD05	6:00A - 2:30P	F/S	
		WPS-LSM-4	D-GD05	6:00A - 2:30P	F/S	Not to be bid until fully staffed
		WPS-LSM-5	S-MP02	2:00P - 10:30P	S/M	
		WPS-LSM-6	S-MP07	2:00P - 10:30P	F/S	
		WPS-LSM-7	G-MN07	10:00P - 6:30A	F/S	
		WPS-LSM-8	G-MN01	10:00P - 6:30A	S/S	
		WPS-LSM-9	G-MN03	10:00P - 6:30A	S/M	Lead-WFM-Fri/Sat
		WPS-LSM-10	G-MN03	10:00P - 6:30A	S/M	

Yard: **Way, Power & Signal**

Shift: All

Effective Date: 1/11/2021

Name		Control #	Work Sched	Hours	Day Off	Remarks
[redacted]		WPS-LST-1	D-GD01	6:00A - 2:30P	S/M	
		WPS-LST-2	D-GD01	6:00A - 2:30P	S/M	
		WPS-LST-3	D-GD05	6:00A - 2:30P	F/S	Lead
		WPS-LST-4	D-GD05	6:00A - 2:30P	F/S	