From: Mike Heitmann
Sent: Monday, March 16, 2020 2:22 PM
Subject: Coronavirus Update
Attachments: EE FMLA WH380E.pdf; GARNEY NOTICE for EMPLOYEE FMLA.pdf; Designation Notice FMLA WH382.pdf

Good Afternoon Employee Owners,

In response to the Coronavirus pandemic, we are taking steps to address a number of concerns. First and foremost, we want to maintain a safe workplace and adopt practices protecting the health of our employee owners. In addition, we want to ensure the continuity of our business operations as practically as possible.

WORKING ENVIRONMENTS:

- Salaried and Office-Hourly employee owners, who are capable of performing their job from home, may work from home over the next two weeks. If you choose to do this, please inform your Supervisor. If you are unsure whether your job can be performed from home, please discuss with your Supervisor.
- When working at a Garney office or jobsite, please practice "social distancing" as best as you can. Garney is preparing social distancing plans within our offices and jobsites to facilitate this.
- If you have a fever and/or are not feeling well, stay home.

BUSINESS TRAVEL:

- All non-essential business travel should be cancelled through April 30, 2020.
- All events are cancelled for the next 8 weeks including:
    - March 20th – Speakeasy, Kansas City
    - April 7th-9th – Business Literacy Training in Kansas City
    - April 17th – Operator Workshop in Houston/Beaumont
    - April 29th – Plant FE Training in Kansas City
    - April 29th – May 1st – Field Managers Workshop in Kansas City
- Any local or Profit Center trainings not listed above should be cancelled through April 30, 2020.

PERSONAL TRAVEL:

- Garney is following the rules for travel outside of the United States as outlined by the CDC. The attached link provides the latest updates of countries impacted. Garney is requesting all employee owners to comply with these rules. https://www.cdc.gov/coronavirus/2019-ncov/travelers/index.html
- Travel to Level 3 (red) areas should be avoided, and a 14-day self-quarantine will be required. Per the State Department, please reconsider traveling outside of the United Sates at this time.

PAID TIME OFF:

Garney is adopting the following paid time off policy during this time:

- All Salaried, Office Hourly and Hourly Field Craft employee owners will receive an additional 10 days (80 hours) of sick leave beyond what is typically provided.
- All Salaried, Office Hourly and Hourly Field Craft employee owners will receive at least two-thirds of their normal wages, up to twelve weeks, if they need to care for a family member, or to care for a child whose

school has closed, or if a child care provider is unavailable. Employee Owners should email hr@garney.com to initiate this process.

- Family Medical Leave is also available to all Salaried, Office Hourly and Hourly Field Craft employee owners and can be initiated by notifying benefits at hr@garney.com.
- Additional information and the forms needed to utilize these benefits are attached.

EMAIL HOTLINE:

- **If you have questions about the above requirements, you may email covid19@garney.com to get your question answered**. Questions can be submitted in English or Spanish.

The *Centers for Disease Control and Prevention* and the *World Health Organization* have the most updated information about how to protect yourself and your family. These sites are updated daily.

If you are located in one of our field offices, please forward or print this email for our Hourly Field Craft employee-owners who do not have a Garney email address. Our response team is meeting daily to address the continually changing environment. We will keep the company updated as new information is available.

Please be assured that Garney is in a strong financial position, and we will weather this storm. Our first priority is taking care of all of you and your families. We will be tested over the next few months, but we will emerge as strong as ever and continue building this great company.

Mike Heitmann
Employee-Owner Since 1990
GARNEY CONSTRUCTION *Advancing Water*

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

U.S. Department of Labor
Wage and Hour Division

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

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

SECTION I: For Completion by the EMPLOYER

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

Employer name and contact: _____

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

Employee's essential job functions: _____

_____

Check if job description is attached:

SECTION II: For Completion by the EMPLOYEE

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

Your name: _____
First Middle Last

SECTION III: For Completion by the HEALTH CARE PROVIDER

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

Provider's name and business address: _____

Type of practice / Medical specialty: _____

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

PART A: MEDICAL FACTS

1. Approximate date condition commenced: _____

   Probable duration of condition: _____

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

   _____

   Date(s) you treated the patient for condition:

   _____

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

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

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

   _____

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

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

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

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

   _____

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

   _____

   _____

   _____

   _____

   _____

   _____

   _____

PART B: AMOUNT OF LEAVE NEEDED

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

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

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

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

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

   _____

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

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

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

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

   _____

   _____

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

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

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

ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER.

_____

_____

_____

_____

_____

_____

Signature of Health Care Provider **Date**

PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT

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

Notice for Employee Covered by the Family and Medical Leave Act 1993

As an employee you are eligible to receive FMLA benefits if you have worked for us 12 consecutive months or 1,250 hours during the 12 month period before the date your absence begins.

The FMLA provides that, if you meet the eligibility requirements, you must be allowed to take time off for up to 12 workweeks in a leave year for the followingconditions:

1.- Birth, adoption or foster care of a child.
2.- Serious health condition of an immediate familymember.
3.- Serious health condition of employee.
4.- Military Family Leave

The 12 month period is calculated starting from the date the employee begins an FMLA approved leave. Leave to provide care for the birth, adoption or foster care of a child must be completed within one (1) year of the birth or placement of the child.

Documentation on Request for Absence

It is your responsibility as an employee to make the FMLA request first verbally to your supervisor and follow up by completing a written request that must be submitted to Human Resources.

The company may require medical certification to support a request for leave because of serious health condition. If a serious health condition is a result of a job related injury or illness, the documentation requirements are provided separately in accordance with Worker's Compensation policies andprocedures.

Benefits

For the duration of FMLA, the company will maintain your health coverage under our group health plan, you must continue to pay the employee portion of the premiums at the time the request is submitted based on the calculated time the employee will be away from work. Failure to make the payment will result in termination of coverage.

Placement and Documentation on Return to Duty

At the end of your FMLA covered absence, you will return to your same job or a job with equivalent status and pay. If you are returning to work after an absence due to your own incapacitation, you must provide certification from your health care provider that you are able to return to work and perform the essential functions of your position without posing a hazard to yourself or others.

For further information please refer to your Leave of Absence policy in your Employee Policy Manual or contact Human Resources at the corporate office 816-746-7263.

Designation Notice (Family and Medical Leave Act)

U.S. Department of Labor
Wage and Hour Division

U.S. Wage and Hour Division

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

Leave covered under the Family and Medical Leave Act (FMLA) must be designated as FMLA-protected and the employer must inform the employee of the amount of leave that will be counted against the employee's FMLA leave entitlement. In order to determine whether leave is covered under the FMLA, 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. While use of this form by employers is optional, a fully completed Form WH-382 provides an easy method of providing employees with the written information required by 29 C.F.R. §§ 825.300(c), 825.301, and 825.305(c).

To: _____

Date: _____

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

_____ **Your FMLA leave request is approved. All leave taken for this reason will be designated as FMLA leave.**

The FMLA requires 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: _____

_____ 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 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):

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

_____ We are requiring you to substitute or use paid leave during your FMLA 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 leave request can be approved:**

_____ The certification you have provided is not complete and sufficient to determine whether the FMLA applies to your leave request. You must provide the following information no later than _____, unless it is not
(Provide at least seven calendar days)
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 right 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 Leave request is Not Approved.
_____ The FMLA does not apply to your leave request.
_____ You have exhausted your FMLA leave entitlement in the applicable 12-month period.

PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT

It is mandatory for employers to inform employees in writing whether leave requested under the FMLA has been determined to be covered under the FMLA. 29 U.S.C. § 2617; 29 C.F.R. §§ 825.300(d), (e). 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 10 – 30 minutes for respondents to complete this collection of information, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, U.S. Department of Labor, Room S-3502, 200 Constitution Ave., NW, Washington, DC 20210. **DO NOT SEND THE COMPLETED FORM TO THE WAGE AND HOUR DIVISION.**