

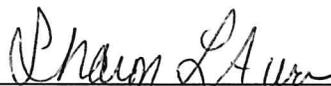
RESOLUTION 2012-596

**RESOLUTION OF THE TOWNSHIP OF BARNEGAT,
COUNTY OF OCEAN, STATE OF NEW JERSEY,
AUTHORIZING AN UNPAID MEDICAL LEAVE
TO DONNA DELILLIO**

BE IT RESOLVED by the Mayor and the Township Committee of the Township of Barnegat, County of Ocean, State of New Jersey that an unpaid medical leave is hereby granted to Donna Delillio from December 3, 2012 through February 28, 2012.

CERTIFICATION

I, Sharon L. Auer, Acting Municipal Clerk of the Township of Barnegat, County of Ocean, State of New Jersey do hereby certify that the foregoing resolution was duly adopted by the Township Committee of said Township at their regular meeting held on the 3rd day of December, 2012 in the Municipal Complex, 900 West Bay Avenue, Barnegat, New Jersey.



Sharon L. Auer
Acting Municipal Clerk



capitahealth

**CAPITAL INSTITUTE
FOR NEUROSCIENCES**

Two Capital Way
Suite 456
Pennington, New Jersey 08534
609 537 7300
609 537 7301 Fax
capitalneuro.org

Erol Veznedaroglu, MD, FACS, FAHA
Director, Capital Institute for Neurosciences
Chairman, Department of Neurosurgery

Neurosurgery

Erol Veznedaroglu, MD, FACS, FAHA
Kenneth M. Liebman, MD, FACS
Mandy J. Binning, MD
Lee Buono, MD, FACS
Joseph Sherrill, MD, FACS, FAANS

Neurology

Mitchell J. Rubin, MD, FAAN
Director, Neurology
Mitra Assadi, MD
Rajat Kumar, MD
Rajesh Sachdeo, MD, FAAN
Chirag S. Shukla, MD
James A. Ware, Jr., MD
Johanna Demirjian, APN,C

Pain Management

Stephen Boyajian, DO
Kenneth Rogers, DO

Physical Medicine & Rehabilitation

Ronald H. Gonzalez, MD

Date: November 21, 2012

To Whom It May Concern:

Please be advised that Donna Dell'Ilia

Is currently under my care for the treatment of _____

ICA aneurysm. Post angiography
Patient is to have no duties until
be assessed at follow-up appointment
February 2013.

If there are any comments or questions please feel free to contact my office.

Sincerely,

Erol Veznedaroglu, M.D.

Kenneth M. Liebman, M.D.

Mandy Jo Binning, M.D.

Donna Delilio
18 James Hollow Road
Barnegat, NJ 08005

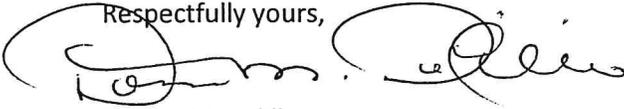
November 6, 2012

Dear Mr. Breeden,

Due to my current illness I am requesting an unpaid medical leave to start November 19, 2012. I am not sure the length of time that I will need as my doctor is running tests and we have yet to receive any definitive answers as to the cause of my illness. Therefore, I will be sure to notify the township as soon as I have more information as to the amount of time I will need to tend to my medical condition.

Please allow me to thank you in advance for the consideration of the approval of this leave.

Respectfully yours,

A handwritten signature in black ink, appearing to read 'Donna M. Delilio', written in a cursive style.

Donna M. Delillio

CC: Sharon L. Auer, Municipal Clerk
Kathleen Janeski, CFO
Teri I. Kirchner, Payroll Coordinator

Revised 11/16/12
Updated Paperwork
for D.D.

ATLANTIC SURGICAL GROUP,
MARK R. SCHWARTZ, M.D., F.A.C.S.
ARON L. GORNISH, M.D., F.A.C.S.
GLENN S. PARKER, M.D., F.A.C.S., F.A.
THOMAS R. LAKE III, M.D., F.A.C.S., F.A.
JEFFREY M. LIN, M.D.

NOV 16 20 12

This is to certify that

Donna De Lillo

Is under my care for the following: *surgery*
The patient had surgery on
11/13/12 & will be out of
work for approx 2 weeks

Jeffrey M. Lin

M.D.

POPLAR BROOK BUILDING
255 MONMOUTH ROAD
OAKHURST, NJ 07755
732-531-5445

459 JACK MARTIN BOULEVARD
SUITE 7
BRICK, NJ 08724
732-836-1500

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

U.S. Department of Labor
Employment Standards Administration
Wage and Hour Division



OMB Control Number: 1215-0181
Rev. 12/1/2011

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(e)(1), if the Americans with Disabilities Act applies.

Employer name and contact: Barnegat Township

Employee's job title: TACO

Regular work schedule: 8:30-4:30 M-F

Employee's essential job functions: Clerical

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(e)(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:

Donna M. DeLillo
First Middle Last

SECTION III: For Completion by the HEALTH CARE PROVIDER

INSTRUCTIONS to the HEALTH CARE PROVIDER: Your patient has requested leave under the FMLA. Answer, fully and completely, all applicable parts. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can; terms such as "lifetime," "unknown," or "indeterminate" may not be sufficient to determine FMLA coverage. Limit your responses to the condition for which the employee is seeking leave. Please be sure to sign the form on the last page.

Provider's name and business address: Thomas R. Lake M.D. 255 Monmouth Rd

Type of practice / Medical specialty: Colon Rectal Surgeon Oakhurst NJ 07755

Telephone: 732 2531-5445

Fax: 732 2531-0225

PART A: MEDICAL FACTS

1. Approximate date condition commenced: 11/12/12

Probable duration of condition: Approx 2 weeks

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:

10/24/12

Will the patient need to have treatment visits at least twice per year due to this 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):

The patient had same day surgery at Ocean Medical Center on 11/13/12

DX-154.3 & 211.4

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: 11/12/12 - 12/2/12 - return to work 12/3/12

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.

