09-28-12
11-MED-03-0309
1735-01
K28846

FOR SERB INTERNAL OFFICE USE ONLY: Employer #_____ Contract #_____

Contract Data Summary Sheet

Employer Name: Wright State University County: Greene

BU: SA Union: FOP Local: OLCI

Start Date: 07 /11 /11 End Date: 06 /30 /14

WAGE:	*PAGE:*
Aft. Dif.: $___.___/___%	
Eve. Dif.: $___.35 /___%	30
Rank Dif. (Y) N	
Haz. Pay: ___.___/___%	
Ret. Pick-up: _____%	
COLA: (Y) N	
Ed. Incent: (Y) N	
Furlough: (Y) N	
Ret. Incentive: (Y) N	
Field Trip Rate: $_____	
EMT Pay: ___.___	
Type: _____	
Paramedic Pay: ___.___	
Type: _____	

ALLOWANCES:	
Uniform(P/V): V	28
Amt: _____	
Cleaning: (P) NA	
Amt: _____	
Tools: (Y) N	
Amt: _____	
Shoes: $_____	29
Mileage: (IRS Rate)	
Other: _____	
Firearm Prof.: _____	
Freq: _____	
Parking: (Y) Y	19
Tuition: (Y) Y	28

VACATION:	23
<1 Years 0 Days	
1-7 Years 80 ~~Days~~ hours	
8-14 Years 120 ~~Days~~ hours	
15-24 Years 160 ~~Days~~ hours	
25+ Years 200 ~~Days~~ hours	
____ Years ____ Days	
____ Years ____ Days	
____ Years ____ Days	
____ Years ____ Days	
Hol/Vac Combo: _____	

LONGEVITY: (Years)	(Amt.)	(%)	*PAGE:* NA (Type)

PAID LEAVE	
Holidays: 10	22
Personal Days: _____	
Birthday: (Y) N	
Injury Leave: ____/____	
Assault Leave: ____/____	
Union Leave (Y) N	
Holiday Pay: _____	
Fatal Force: (Y) N	

SICK & BEREAVEMENT LEAVE	
Sick Days/Year: 4.6hrs	26
Max Sick: ____/____	
Attendance Bonus: (Y) N	
Bank/Donated Time: (Y) N	
Bereavement Leave:	24
Sick: 5	24
Funeral: _____	
Other: (Y) N	

*INSURANCE**		28
	Single	Family
Employer Amt:	$_____	$_____
Employee Amt:	$_____	$_____
Employer %:	_____	_____
Employee %:	_____	_____
Employer Cap (Y):	____	____
Employee Cap (Y):	____	____
Ann. Deductible:	$_____	$_____
Co-Payment %:	_____	_____

INSURANCE (cont.):	*PAGE:* ____
Out-of-Pocket Max: $_____	$_____
Cover Buy-Out: $_____	$_____
Traditional (Y): ____	____
Managed Care (Y): ____	____
Type (Y): ____	
HMO _____	
PPO _____	
Self-Funded _____	
Partial Self-Funded _____	
Consortium _____	
Liability (Y): ____	____
Section 125: (Y) _____	Type: _____
Enrollment Fee: $_____	
Other: (Y) _____	
Prescriptions: (Y) _____	
Brand Name (Formulary) $_____	
Generic: $_____	
Dental: (Y) Y	
Optical: (Y) Y	
Life Ins. Amt.: $_____	
Life Ins. Salary %: _____	
Accidental D&D: (Y) _____	
Health & Welfare: (Y) _____	
Cap Overage Formula: (Y) _____	
Health Care Committee: (Y) _____	
Coordination of Benefits: (Y) _____	
Major Medical: (Y) _____	
Comprehensive Major Medical: (Y) _____	

* Please use another ***INSURANCE*** form if there are changes to insurance in each contract year.

FOR SERB INTERNAL OFFICE USE ONLY: Employer #_____ Contract #_____

HOURS OF WORK	***PAGE:***
Comp Time Max: _____. Hrs	20
Flex Time: (Y) N	
Call In: (Y) Y .4 Hrs ST	22
Court: (Y) Y 2 Hrs ST	30
Stand By: (Y) N	
Report In: (Y) N . Hrs	
Meal Time: _____. Min	
Rest Break: _____/_____ Min.	22
Overtime Cycle: 40 / 7 .	20

SENIORITY AND ARBITRATION	
Prob. Period: 1 . YR.	20
Shift: (Y) Y	33
Recall Years: 1 . YR	18
Super Seniority (Y) N	
Arb: (Y) Y	15
Type: F/B	16
Cost (E/L/O): E	15
Mediation Step:(Y) N	

OTHER			
Fairshare: (Y) Y			8
Residency: (Y) N			
Drug Test: (Y)	Y	RS	9
Fitness Std.: (Y) N			
Sub-Contract: (Y)	Y/WL		21
Min Staff: (Y) N			
Successor/Priv.: (Y) N			
MAD: (Y) N			

WAGE INCREASE ACROSS BOARD ***PAGE*** 31

Date of Increase ____/____/____

Percent _____%

Hourly $_____

Annual $_____

Lump Sum $_____

Comments For the remainder of the term of this agreement, the job rates for all the classifications shall increase in accordance with the annual increases provided for other non represented University staff, exempt and non exempt

Date of Increase ____/____/____

Percent _____%

Hourly $_____

Annual $_____

Lump Sum $_____

Comments _____

Date of Increase ____/____/____

Percent _____%

Hourly $_____

Annual $_____

Lump Sum $_____

Comments _____

Date of Increase ____/____/____

Percent _____%

Hourly $_____

Annual $_____

Lump Sum $_____

Comments _____

FOR SERB INTERNAL OFFICE USE ONLY: Employer #_____ Contract #_____

BENCHMARKS ***PAGE:*** _____

Job Title Communications Operator 1

Date	07 / 1 / 11	07 / 01 / 12	07 / 01 / 13	/ /	Work Week: 46
					Hrs/Day: 8/DY
Entry	$ 14 . 79	$ 15 . 79	$ 16 . 81	$.	Days/Yr:
					# Steps:
Top	$ 16 . 43	$ 16 . 62	$ 16 . 81	$.	Step Yrs:

Job Title Communications Operator 2

Date	07 / 01 / 11	07 / 01 / 12	07 / 01 / 13	/ /	Work Week: 40
					Hrs/Day: 8/DY
Entry	$ 15 . 13	$ 15 . 97	$ 16 . 81	$.	Days/Yr:
					# Steps:
Top	$ 16 . 81	$ 16 . 81	$ 16 . 81	$.	Step Yrs:

Job Title _____

Date	/ /	/ /	/ /	/ /	Work Week:
					Hrs/Day:
Entry	$.	$.	$.	$.	Days/Yr:
					# Steps:
Top	$.	$.	$.	$.	Step Yrs:

Job Title _____

Date	/ /	/ /	/ /	/ /	Work Week:
					Hrs/Day:
Entry	$.	$.	$.	$.	Days/Yr:
					# Steps:
Top	$.	$.	$.	$.	Step Yrs:

Job Title _____

Date	/ /	/ /	/ /	/ /	Work Week:
					Hrs/Day:
Entry	$.	$.	$.	$.	Days/Yr:
					# Steps:
Top	$.	$.	$.	$.	Step Yrs:

FOR SERB INTERNAL OFFICE USE ONLY: Employer #_____ Contract #_____

Contract Data Summary Sheet

Employer Name: Wright State University County: Greene

BU: SM Union: FOP Local: OLCI

Start Date: 07 /01 /11 End Date: 06 /30 /14

WAGE:	***PAGE:***
Aft. Dif.: $___.___/___%	____
Eve. Dif.: $___.35 /___%	34
Rank Dif. (Y) N	____
Haz. Pay: ___.___/___%	____
Ret. Pick-up: _____%	____
COLA: (Y) N	____
Ed. Incent: (Y) N	____
Furlough: (Y) N	____
Ret. Incentive: (Y) N	____
Field Trip Rate: $_____	____
EMT Pay: ___.___	____
Type: ____	
Paramedic Pay: ___.___	____
Type: ____	

ALLOWANCES:	
Uniform(P/V): V	30
Amt: ____	
Cleaning: (P) ____	____
Amt: ____	
Tools: (Y) N	____
Amt: ____	
Shoes: $_____	31
Mileage: (IRS Rate)	____
Other: _____	
Firearm Prof.: _____	____
Freq: _____	
Parking: (Y) ____	____
Tuition: (Y) Y	30

VACATION:	25
1 Years 0 Days	
1-7 Years 80 ~~Days~~ hours	
8-14 Years 120 ~~Days~~ hours	
15-24 Years 160 ~~Days~~ hours	
24+ Years 200 ~~Days~~ hours	
____ Years ____ Days	
____ Years ____ Days	
____ Years ____ Days	
____ Years ____ Days	
Hol/Vac Combo: ____	____

LONGEVITY:			***PAGE:*** ____
(Years)	(Amt.)	(%)	(Type)
____	____	____	____
____	____	____	____
____	____	____	____
____	____	____	____
____	____	____	____
____	____	____	____
____	____	____	____
____	____	____	____

PAID LEAVE	
Holidays: 10	24
Personal Days: ____	____
Birthday: (Y) N	____
Injury Leave: 240 / hrs	37
Assault Leave: ____/____	____
Union Leave (Y) N	____
Holiday Pay: ____	____
Fatal Force: (Y) N	____

SICK & BEREAVEMENT LEAVE	
Sick Days/Year: 4.6/80	27
Max Sick: ____/____	____
Attendance Bonus: (Y) N	____
Bank/Donated Time: (Y) N	____
Bereavement Leave:	27
Sick: 5	27
Funeral: ____	____
Other: (Y) N	____

INSURANCE*		30
	Single	Family
Employer Amt:	$____	$____
Employee Amt:	$____	$____
Employer %:	____	____
Employee %:	____	____
Employer Cap (Y):	____	____
Employee Cap (Y):	____	____
Ann. Deductible:	$____	$____
Co-Payment %:	____	____

INSURANCE (cont.):	***PAGE:*** ____
Out-of-Pocket Max: $____	$____
Cover Buy-Out: $____	$____
Traditional (Y): ____	____
Managed Care (Y): ____	____
Type (Y): ____	
HMO ____	
PPO ____	
Self-Funded ____	
Partial Self-Funded ____	
Consortium ____	
Liability (Y): ____	____
Section 125: (Y) ____ Type: ____	
Enrollment Fee: $_____	
Other: (Y) ____	
Prescriptions: (Y) ____	
Brand Name (Formulary) $_____	
Generic: $_____	
Dental: (Y) Y	
Optical: (Y) ____	
Life Ins. Amt.: $_____	
Life Ins. Salary %: _____	
Accidental D&D: (Y) ____	
Health & Welfare: (Y) ____	
Cap Overage Formula: (Y) ____	
Health Care Committee: (Y) ____	
Coordination of Benefits: (Y) ____	
Major Medical: (Y) ____	
Comprehensive Major Medical: (Y) ____	

* Please use another ***INSURANCE*** form if there are changes to insurance in each contract year.

FOR SERB INTERNAL OFFICE USE ONLY: Employer #_____ Contract #_____

HOURS OF WORK	***PAGE:***
Comp Time Max: _____. Hrs	_____
Flex Time: (Y) N	_____
Call In: (Y) Y 4 Hrs ST	23
Court: (Y) Y 3 Hrs ST	34
Stand By: (Y) Y	22
Report In: (Y) N . Hrs	_____
Meal Time: _____. Min	_____
Rest Break: _____ / _____ Min.	24
Overtime Cycle: 40 / 7 .	20

SENIORITY AND ARBITRATION	
Prob. Period: 1 . YR.	20
Shift: (Y) Y	36
Recall Years: 12 . mt	18
Super Seniority (Y) N	_____
Arb: (Y) Y	15
Type: F/B	15
Cost (E/L/O): E	15
Mediation Step:(Y) N	_____

OTHER			
Fairshare: (Y) Y			8
Residency: (Y) N			_____
Drug Test: (Y)	Y	RS	9
Fitness Std.: (Y) N			_____
Sub-Contract: (Y)	Y/WL		22
Min Staff: (Y) N			_____
Successor/Priv.: (Y) N			_____
MAD: (Y) N	_____		_____

WAGE INCREASE ACROSS BOARD ***PAGE*** 35

Date of Increase ____/____/____

Percent _____%

Hourly $_____

Annual $_____

Lump Sum $_____

Comments Increases will be effective as of the same date as that of the non represented university staff.

Date of Increase ____/____/____

Percent _____%

Hourly $_____

Annual $_____

Lump Sum $_____

Comments _____

Date of Increase ____/____/____

Percent _____%

Hourly $_____

Annual $_____

Lump Sum $_____

Comments _____

Date of Increase ____/____/____

Percent _____%

Hourly $_____

Annual $_____

Lump Sum $_____

Comments _____

FOR SERB INTERNAL OFFICE USE ONLY: Employer #_____ Contract #_____

BENCHMARKS ***PAGE:***_____

Job Title POLICE OFFICER

Date	07 / 01 / 11	/ /	/ /	/ /	Work Week: 40hr
					Hrs/Day: 8/dy
Entry	$ 19 .85	$ 20 .96	$ 22 .06	$.	Days/Yr:
					# Steps:
Top	$ 22 .06	$ 22 .06	$ 22 .06	$.	Step Yrs:

Job Title POLICE SERGEANT

Date	07 / 01 / 11	/ /	/ /	/ /	Work Week: 40hr
					Hrs/Day: 8/dy
Entry	$ 24 .27	$ 25 .62	$ 26 .97	$.	Days/Yr:
					# Steps:
Top	$ 26 .97	$ 26 .97	$ 26 .97	$.	Step Yrs:

Job Title _____

Date	/ /	/ /	/ /	/ /	Work Week:
					Hrs/Day:
Entry	$.	$.	$.	$.	Days/Yr:
					# Steps:
Top	$.	$.	$.	$.	Step Yrs:

Job Title _____

Date	/ /	/ /	/ /	/ /	Work Week:
					Hrs/Day:
Entry	$.	$.	$.	$.	Days/Yr:
					# Steps:
Top	$.	$.	$.	$.	Step Yrs:

Job Title _____

Date	/ /	/ /	/ /	/ /	Work Week:
					Hrs/Day:
Entry	$.	$.	$.	$.	Days/Yr:
					# Steps:
Top	$.	$.	$.	$.	Step Yrs: