STATE PERSONNEL BOARD, STATE OF COLORADO
Case No. **2006B097**

INITIAL DECISION OF THE ADMINISTRATIVE LAW JUDGE

DOROTHY EMERSON,

Complainant,

vs.

DEPARTMENT OF HUMAN SERVICES,

Respondent.

Administrative Law Judge Mary S. McClatchey held the hearing in this matter on May 10 and 17, 2006 at the State Personnel Board, 633 17th Street, Denver, Colorado. The record remained open until May 19, 2006 for the submission of supplemental authority. Complainant appeared and was represented by Teresa Zoltanski, Esquire. Respondent was represented by Assistant Attorney General Roberta Lopez.

MATTER APPEALED

Complainant, Dorothy Emerson (Complainant) appeals her disciplinary reduction in pay in the amount of 5% for 30 days by Respondent Department of Human Services (Respondent or DHS). Complainant seeks reinstatement of the pay deducted from her paycheck.

For the reasons set forth below, Respondent's action is **rescinded.**

ISSUES

1. Whether Complainant committed the acts for which she was disciplined;

2. Whether Respondent's action was arbitrary, capricious or contrary to rule or law;

3. Whether the discipline imposed was within the range of reasonable alternatives available to the appointing authority.

FINDINGS OF FACT

General Background

1. Complainant has been a Licensed Practical Nurse ("LPN") for fifteen years. She was a Certified Nurse Aide for fifteen years prior to becoming an LPN. She has worked in nursing home facilities for her entire career.

2. Complainant was certified in the position of LPN Tech III at Colorado State Veterans Home – Fitzsimons (Fitzsimons), at all times relevant.

3. The primary duties of LPN's at Fitzsimons are to administer medications and treatments to residents; to provide direct care to patients, such as feeding, clothing, and cleaning; and to supervise the nurse aides in the performance of their duties.

The Admissions Process

4. Registered nurses (RN's) are exclusively responsible for handling the process of admitting residents to Fitzsimons. The admissions process consists of two major components: the physical assessment of the resident (including charting of information in the resident's medical record), and contacting the resident's treating physician to report the admission and to obtain medication and treatment orders.

5. The second portion of the admissions process will be referred to hereafter as the "physician contact" portion.

6. RN's are not permitted to delegate the physical assessment portion of patient admission to an LPN.

7. RN's are permitted to delegate the physician contact component of the admissions process to an LPN, because it does not require any analysis of patient care.

8. To perform the physician contact portion of a patient admission, an individual places a telephone call to the treating physician, informs the physician that the patient is being admitted, and requests all orders in effect for the patient. The individual then documents those orders, including medication and treatment orders, in the patient's medical record, including the Medication Administration Record ("MAR").

9. During Complainant's tenure as an LPN, she has performed the physician contact portion of patient admissions. She has contacted doctors by telephone to report the admission of a resident and to obtain orders for medications and treatments.

10. It normally takes approximately ten to fifteen minutes to call the doctor's office and obtain orders for an incoming patient.

11. The customary practice at Fitzsimons was for RN's to perform the entire admissions process, without delegating the physician contact portion to an LPN. However, RN's did occasionally delegate this portion to an LPN.

January 9, 2005

12. On January 9, 2005, Complainant worked on the Constitution Unit at Fitzsimons. She was responsible for the front-line nursing care of approximately 17 residents on that unit, partly through her supervision of nurse aides.

13. On January 9, 2005, there was a potential flu outbreak at the facility. Ruth Minnema, the Director of Nursing ("DON"), called in several managerial level RN's at the facility, to work an extra shift administering anti-viral medication. The purpose of their presence was to mitigate against the potential outbreak of flu at the facility.

14. Complainant had three residents on her unit with high fevers, who were at risk of contracting the flu. It was a stressful shift for Complainant and the entire nursing staff at Fitzsimons.

15. At the beginning of Complainant's shift, the house supervisor RN, Linda Woods, informed Complainant that a Patient, Mr. P, had been re-admitted to Fitzsimons from the hospital. Mr. P was on Complainant's unit; therefore, Complainant was responsible for providing direct care to him, including medications and treatments.

16. Woods performed the physical assessment portion of the admission of Mr. P. Then, she ordered Complainant to perform the physician contact portion of Mr. P's admission. She told Complainant to contact his doctor and obtain medication and treatment orders.

17. Complainant started the process by calling the nurses at the hospital from which he had just transferred. She took a nurse's report from the hospital nurse.

18. Complainant never called Mr. P's doctor to obtain orders for medications and treatments.

19. Complainant was very busy. She repeatedly mentioned to the RN's at the facility that she needed help with the admission for Mr. P. However, the RN's were too busy addressing the possible flu outbreak throughout the entire building to assist Complainant.

20. At the end of the shift, one of the supervising RN's asked Complainant if she had obtained the orders from Mr. P's physician. Complainant responded that she had not done so, and explained that she had repeatedly asked for help during her shift from the RN's present, but had received no assistance.

21. The supervising RN informed Director of Nursing Minnema of the situation. Minnema called Mr. P's physician and obtained the orders for him. It took her ten minutes to do so.

22. Minnema was very concerned about Complainant's failure to appropriately prioritize her duties during her shift. Therefore, she met with Complainant, and directed her to develop a plan of action for the future, which would assure she did not repeat the same error.

23. Minnema also put Complainant on a performance monitoring plan for one month. Under this plan, Complainant checked in with supervising RN's on her shift, to assure that she was appropriately prioritizing her work. In addition, Minnema directed Complainant to submit a plan of correction.

24. On January 24, 2005, Complainant submitted her plan of correction to Minnema. She reviewed the circumstances on January 9, and concluded as follows: "My plan in dealing with this situation as a LPN TECH III, would be try to notify the physician, verify the orders, and order medications, even thought with the work load, I might not be on time with all of my other duties. I would notify the RN supervisor I have an admission and to ask for help. I would do the best I could do in performing the tasks I am assigned to do in my scope of practice."

25. Complainant claimed at hearing to have been ordered to perform the entire assessment" on Mr. P, and not to have been ordered only to contact the doctor and obtain orders. She therefore asserts that Woods' order was an improper delegation of the entire assessment function. This testimony is rejected on the basis that Complainant's January 24, 2005 letter confirms that she knew she was being asked to "notify the physician and confirm the orders." Further, the letter makes no reference to being asked to perform a task beyond the scope of her LPN license.

January 28, 2005

26. On January 27, 2005, at 6:00 p.m., a resident, Mr. C, was admitted from Odyssey hospice home to Fitzsimons, as a hospice patient. Hospice patients are near death; the priority for their care is to assure their maximum comfort through pain management.

27. Odyssey staff were responsible for assuring that Fitzsimons received physician orders, and the actual medications and treatments, for Mr. C. This did not occur.

28. Fitzsimons staff on January 27, 2005 shared responsibility for assuring Mr. C's orders, medication, and treatments were present at Fitzsimons. This also did not occur.

29. During the evening of January 27 and the graveyard shift of January 27 – 28, Mr. C received no pain medication or treatments of any kind at Fitzsimons. His level of pain increased and his condition worsened.

30. Complainant arrived for her morning shift on January 28, 2005. She immediately noticed that Mr. C had not been properly admitted to Fitzsimons and that none of his medications or treatments were there. She was concerned that he had not received any pain relief. Complainant immediately contacted the building Supervisor, Nurse Practitioner Paul Baynham, and informed him that Mr. C still did not have any medication or treatments in the building, despite his admission the previous evening.

31. Baynham had actually seen Mr. C at the hospital on January 27, prior to his transfer to Fitzsimons. He noticed that Mr. C's condition had worsened considerably.

32. Baynham immediately opened the emergency medication box and gave pain medication to Complainant. She administered the pain medication to Mr. C at 7:45 a.m. She then charted the administration of that medication on the back of the MAR, in the section for nurses' notes. She signed with her initials in cursive, "DE."

33. Baynham then reported to Minnema that the admission of Mr. C had not gone well. He explained that the nurses on the two previous shifts had failed to assure that Odyssey delivered Mr. C's pain medication.

34. Baynham also reported to Minnema that Complainant had been the first nurse on staff to identify the problem and to report it to a nursing supervisor, himself. Lastly, he reported that he and Complainant had given Mr. C the emergency administration of pain medication.

35. As Baynham reported the series of events to Minnema, he noted to himself that Minnema appeared inordinately focused on possible misconduct by Complainant.

36. One of Mr. C's treatments was a nebulizer for his acute respiratory condition. At no time during Complainant's shift on January 28 was the nebulizer treatment for Mr. C available at Fitzsimons. It would have been impossible to administer the nebulizer to Mr. C.

37. At some time on or after January 28, someone at Fitzsimons entered a "D" next to the nebulizer treatment administration for 8:00 a.m. and 12:00 a.m. The entry indicates that the nebulizer was administered. However, because it was not

present in the building, it would have been impossible for anyone to administer it. The record does not demonstrate who made these entries.

38. Complainant did not write the "D" on Mr. C's chart, for the 8:00 a.m. and 12:00 nebulizer treatments for Mr. C. This finding is based on the following:

    a. Complainant was the first nurse on staff at Fitzsimons to take action to assure Mr. C received pain medication. She was keenly aware that none of his medications or treatments, including the nebulizer, were at Fitzsimons. Complainant therefore had no reason or motive to falsify the record for Mr. C;

    b. Complainant's customary initial consisted of a cursive "DE," which is what she wrote when she administered the pain medication to Mr. C. This entry is materially different from the "D" entries for the nebulizer treatment at 8:00 and 12:00;

    c. Complainant has steadfastly denied that the "D" is hers;

    d. There is no evidence in the record establishing that the "D" entries are in Complainant's handwriting.

39. The admitting nurse for Mr. C, Ms. Pijanowski, later questioned Complainant about the nebulizer entries on the MAR. Complainant initially responded that if she had charted it, she had given the treatment. When Pijanowski asked her where she had gotten them from, Complainant recalled that she actually had not given him any nebulizer treatment (because it was not available). Pijanowski informed Complainant that she had signed the MAR as having given the treatment. Complainant stated that she did not recall having done that.

40. On January 30, 2005, Pijanowski made a written report of the incident to Minnema. Pijanowski stated that Complainant "signed off Nebulizer medications as given at 0800 and 1200, when in fact the medication was not available. This is providing false information. What should have occurred was that her initials be circled to indicate that the medication was not given, and the reason why documented on the back of the med sheet. In addition, a Supervisor should have been notified that the medication was not available. In the future, Dorothy will immediately notify a Supervisor when a medication is not available, and document accordingly. Failure to do so will result in disciplinary action."

41. Minnema repeatedly brought the MAR for Mr. C to Complainant and asked her if she had made the nebulizer entries. She denied having done so.

42. Minnema reported the events of January 9 and her concerns about falsification of Mr. C's medical record to Shelly Uhrig, the appointing authority for Fitzsimons.

43. On February 1, 2005, Uhrig sent a letter to Complainant indicating the possible need to administer disciplinary action "based upon alleged falsification of resident medical records." The letter contains no reference to the January 9 failure to contact Mr. P's doctor to obtain orders.

44. On February 5, 2005, Complainant wrote a letter in response to the February 1, 2005 letter. She explained that Mr. C had been admitted to the unit the day before her shift, and that none of the nursing staff on the previous two shifts had taken action to obtain his medication and treatments from Odyssey. She detailed that at the outset of her shift, she looked for and found no medication or treatments for Mr. C and immediately reported it to the Supervisor for the facility, Mr. Baynham.

45. Regarding the entries on the MAR for nebulizer treatment, Complainant stated, "I honestly cannot remember providing false information on 1/28/05. On the Eagles unit this day, I had a census of 24 patients. In all of my years as a nurse, I used a system of not signing off medications until they are given. If a medication is drawn up and not given, I know to circle not given and the reason why and destroy the medication if necessary and document. This is the way I try to work to eliminate mistakes. On seeing the medication was not in from the night shift, I notified the Supervisor the patient's medications were not in. I would not have signed for medications that I knew were not available to be given. I am a conscientious nurse and attentive to details and my assignment."

46. Complainant also stated in her letter that she has been an LPN for 15 years, and a nurse aide for 15 years prior to that, with no prior performance issues. Complainant also expressed her dedication to the nursing profession and to providing good care to her patients.

47. Complainant called Uhrig to ask if she needed a representative at the pre-disciplinary meeting. Uhrig responded that it was an informal meeting and there was no need for an attorney.

Pre-Disciplinary Meeting

48. On February 7, 2005, Complainant met with Uhrig. Uhrig began the meeting by reading the January 30 memo by Pijanowski. Uhrig indicated that she had read Complainant's February 5 letter, and acknowledged that Complainant stated she had notified a supervisor about the missing medications for Mr. C.

49. Complainant explained what had occurred on the morning shift on January 28, 2005, with Mr. Baynham.

50. Uhrig stated, "Part of the problem being is you signed off on the MARs that it [the nebulizer] was given." Complainant responded, "I, I, that's not what I do. I just

don't understand that now. . . . I can't remember doing that and I, I just don't' understand because . . . I just don't do that. . ."

51. Complainant explained that she had initially told Ms. Pijanowski, "if I charted it, I gave it," because that would normally be the case. However, she explained that she specifically recalled that Mr. C "didn't have any nebs." She denied having charted that she gave Mr. C the nebulizer treatment.[1]

52. During the meeting, Uhrig does not refer to the actual MAR to examine the handwriting.

53. Ms. Uhrig then stated, "and one thing that also caused me a little concern is on January 17th [actually January 9], this is a previous issue, that Ruth met with you to discuss a resident re-admission and you didn't notify that the physician, uh the physician that the resident had returned from the hospital and didn't confirm the orders or the medications. Um, can you, can you tell me a little bit about that?"

54. Complainant responded that she wrote a letter about that and gave it to Minnema. Uhrig stated that she had the letter in her possession. The two then reviewed the contents of Complainant's letter, in which she explained how many times she had asked for assistance with the admission.

55. Uhrig explains the importance of obtaining the physician's orders, because if a medication is given without having done that, she would be practicing [medicine] on her own.

56. Complainant explained that she took report from the hospital nurse and that she should have confirmed his orders.

57. Uhrig concludes, "So you're aware of how important that is and it will never happen again." Complainant responds, "Yes."

58. The transcript [and the tape] of the meeting indicates that Uhrig then makes a statement about admitting to signing off something. However, the statements after that are inaudible.

59. Complainant had no clear recollection of having made the "D" entries on Mr. C's MAR on January 28. She stated, "I don't usually do that, that's not what I usually do. There must have been some circumstances that, uh, you know that was prevailing. But, I don't usually do that, I, all these years I've never had anything negative . . . on my nurse's record. . . ." The remainder of the meeting is inaudible.

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[1] Exhibit 9, page 4, line 12.

60. Uhrig considered the fact that Complainant had asked for assistance in calling Mr. P on January 9, 2005. Unrig concluded that in the time Complainant asked for assistance, she could have simply made the call to the doctor's office.

61. Uhrig never compared the 8:00 and 12:00 entries, with just the letter, "D," to Complainant's other entry on the same MAR, which contained the initials, "DE" in cursive.

62. Uhrig did not interview the facility supervisor who worked with Complainant on January 28, 2005, Mr. Baynham.

63. Ms. Uhrig did not review Complainant's performance evaluations prior to imposing disciplinary action.

64. There is no evidence that Ms. Uhrig considered Complainant's lack of prior corrective or disciplinary action in making her decision.

65. Uhrig decided to impose disciplinary action against Complainant because she believed that with two incidents in one month, Complainant was demonstrating a pattern of lack of attention to policies and procedures. She sought to send a message to Complainant, "Let's be more studious and pay attention."

66. On February 16, 2005, Uhrig issued the disciplinary action letter. The second paragraph quotes Ms. Pijanowski's January 30, 2005 memo almost verbatim. It states, "on January 28, 2005, you signed off on the Medication Administration Record (MAR) that you administered a Nebulizer medication at 0800 and 1200, when in fact the medication was not available. This is providing false information. What should have occurred was that your initials should have been circled to indicate that the medication was not given, and the reason why the medication was not given should have been documented on the back of the MAR. In your supplemental written documentation that you provided, you indicated that you were aware the medication was not available, as you informed a nurse supervisor. You then signed the MAR as if you had given the medication."

67. The letter also stated, "On January 17, 2005 [actually January 9], you failed to notify the attending physician that a resident had returned from the hospital. This means that the physician orders for medications and treatment were not confirmed, and were administered without the attending physician's approval."

68. The letter then placed Complainant on a thirty-day monitoring plan with the Director of Nursing.

69. Complainant timely appealed the disciplinary action.

DISCUSSION

I. GENERAL

Certified state employees have a property interest in their positions and may only be disciplined for just cause. Colo. Const. Art. 12, §§ 13-15; §§ 24-50-101, *et seq.*, C.R.S.; *Department of Institutions v. Kinchen*, 886 P.2d 700 (Colo. 1994). Such cause is outlined in State Personnel Board Rule 6-12, 4 CCR 801, and generally includes:

(1) failure to comply with standards of efficient service or competence;
(2) willful misconduct including either a violation of the State Personnel Board's rules or of the rules of the agency of employment;
(3) false statements of fact during the application process for a state position;
(4) willful failure or inability to perform duties assigned; and
(5) final conviction of a felony or any other offense involving moral turpitude.

A. Burden of Proof

In this *de novo* disciplinary proceeding, the agency has the burden to prove by preponderant evidence that the acts or omissions on which the discipline was based occurred and that just cause warranted the discipline imposed. *Department of Institutions v. Kinchen*, 886 P.2d 700 (Colo. 1994). The Board may reverse Respondent's decision if the action is found to be arbitrary, capricious or contrary to rule or law. Section 24-50-103(6), C.R.S.

II. HEARING ISSUES

A. Complainant committed one of the acts for which she was disciplined.

Respondent has proven by preponderant evidence that Complainant failed to call Mr. P's doctor on January 9, 2005 to verify his orders, after being ordered to do so by a supervising RN. While Complainant asserts that it was not the normal routine for an RN to delegate this task to an LPN, the shift on January 9 was an extraordinary one due to the potential flu outbreak at Fitzsimons. The evidence demonstrated that the order of the RN was appropriate, albeit unusual, and that Complainant was obliged to follow that order.

Respondent failed to prove by preponderant evidence that Complainant falsified Mr. C's medical record on January 28, 2005. Complainant was the only nurse to come forward to a supervising RN to report the fact that Mr. C was still without medication or treatments. She was the first nurse to see that he received pain relief. Complainant knew the nebulizer treatment was unavailable, and she had no reason to falsify Mr. C's medical record. Significantly, Complainant signed off on the emergency pain reliever for Mr. C in cursive handwriting, with a "DE." This signature was different from the "D" entered for the nebulizer. Complainant has never admitted to having falsified the record. The preponderance of evidence demonstrates that she did not do so.

B. The Appointing Authority's action was contrary to rule.

State Personnel Board Rule 6-2, 4 CCR 801, requires, "A certified employee shall be subject to corrective action before discipline unless the act is so flagrant or serious that immediate discipline is proper. The nature and severity of discipline depends upon the act committed. When appropriate, the appointing authority may proceed immediately to disciplinary action, up to and including immediate termination."

The credible evidence in the record demonstrates that the appointing authority, Ms. Uhrig, did not consider the January 9, 2005 admission incident to be serious or flagrant. This is reflected in her failure to mention it as a subject of potential disciplinary action in her February 1 letter to Complainant, advising her of the impending pre-disciplinary 6-10 meeting. In addition, at the actual 6-10 meeting, Uhrig introduced the issue by stating, "and one thing that also caused me a little concern is on January 17th [actually January 9], this is a previous issue, that Ruth met with you to discuss a resident re-admission and you didn't notify that the physician, uh the physician that the resident had returned from the hospital and didn't confirm the orders or the medications. Um, can you, can you tell me a little bit about that?" The evidence does not support a finding that Complainant's omission on January 9, 2005 was so flagrant or serious that immediate discipline was proper. Board Rule 6-2.

Under the circumstances herein, the evidence does not support Respondent's imposition of disciplinary action against Complainant, prior to corrective action. Rule 6-2. The record indicates that Complainant has had no prior performance issues. Further, no evidence was offered by either party concerning Complainant's evaluations. Therefore, they are presumed to have been at least satisfactory. An employee whose first infraction is minor in nature, and is neither flagrant nor serious, is, per Board Rule 6-2, entitled to receive a corrective action prior to a disciplinary action. Therefore, the disciplinary action must be rescinded.

C. The disciplinary action was arbitrary and capricious.

In determining whether an agency's decision is arbitrary or capricious, a court must determine whether the agency has 1) neglected or refused to use reasonable diligence and care to procure such evidence as it is by law authorized to consider in exercising the discretion vested in it; 2) failed to give candid and honest consideration of the evidence before it on which it is authorized to act in exercising its discretion; 3) exercised its discretion in such manner after a consideration of evidence before it as clearly to indicate that its action is based on conclusions from the evidence such that reasonable men fairly and honestly considering the evidence must reach contrary conclusions. *Lawley v. Department of Higher Education,* 36 P.3d 1239, 1252 (Colo. 2001).

In assessing whether appointing authorities have acted in an arbitrary and capricious manner under *Lawley*, it is essential to examine whether they have complied

with Board Rule 6-9. That rule requires, "The decision to take corrective or disciplinary action shall be based on the nature, extent, seriousness, and effect of the act, the error or omission, type and frequency of previous unsatisfactory behavior or acts, prior corrective or disciplinary actions, period of time since a prior offense, previous performance evaluations, and mitigating circumstances. Information presented by the employee must also be considered." As noted above, there is no evidence in the record that Ms. Uhrig considered Complainant's lack of corrective or disciplinary actions in the past, or her previous performance evaluations, prior to imposing disciplinary action. Both of these factors serve as mitigation.

In addition, Ms. Uhrig failed to give candid and honest consideration to the mitigating information Complainant provided in her February 5 letter. In that document, Complainant thoroughly explained the circumstances on February 28 to Uhrig: Complainant discovered there were no treatments or medications for Mr. C in the building, despite his admission the previous evening; she immediately reported that fact to the building Supervisor; she administered an emergency pain reliever; and that was the end of it. As compared to the other nurses assigned to Mr. C, Complainant shined. Complainant was keenly aware of and concerned about the fact there was no nebulizer in the building. To conclude that she then falsified the record about having administered the nebulizer lacks logic and common sense.

Ms. Uhrig failed to step back from the situation and to objectively assess Complainant's role in the care and treatment of Mr. C on January 28, 2005. A discussion with the Supervisor, Mr. Baynham, would have clarified Complainant's positive role in the care and treatment of Mr. C on that day, and would have put to rest the anomalous assumption that she intentionally falsified his medical record.

Lastly, the credible evidence demonstrates that the appointing authority failed to use reasonable diligence and care to review the documentary evidence upon which she based the discipline, prior to making her decision, in violation of the *Lawley* standard. With regard to the alleged falsification of the MAR, Ms. Uhrig did not compare Complainant's charting entry for the emergency pain reliever to the entry made for the nebulizer. Had she done so, she would immediately have discovered that the pain medication entry contains two initials, and the nebulizer entry contains just one letter, and that it is impossible to establish they are in the same handwriting. The evidence showed that she was unaware of these facts at the time she imposed discipline.

D. The discipline imposed was not within the range of reasonable alternatives.

The above discussion makes it clear that the discipline imposed is not within the range of reasonable alternatives. Respondent failed to prove just cause to discipline Complainant, because it failed to prove one of the two violations upon which discipline was based. Had Respondent proven a pattern of misconduct, such a pattern would form an appropriate basis for the minor discipline of a 5% pay reduction imposed herein. However, Respondent proved only that Complainant committed a minor infraction on January 9, 2005. The evidence demonstrates that this incident was not flagrant or

serious. Therefore, under Board Rule 6-2, Respondent was required to impose corrective action, and the disciplinary action taken was not within the range of reasonable alternatives.

CONCLUSIONS OF LAW

1. Complainant committed one of the acts for which she was disciplined;

2. Respondent's action was arbitrary, capricious, or contrary to rule or law;

3. The discipline imposed was not within the range of reasonable alternatives.

ORDER

Respondent's action is **rescinded**. Respondent shall remove the disciplinary action from Complainant's personnel file, and shall reimburse her for the 5% in pay for thirty days that was deducted from her paycheck. Respondent may impose a corrective action in place of the disciplinary action.

Dated this 29th day of June, 2006

Mary S. McClatchey
Administrative Law Judge
633 – 17th Street, Suite 1320
Denver, CO 80202
303-866-3300

NOTICE OF APPEAL RIGHTS

EACH PARTY HAS THE FOLLOWING RIGHTS

1. To abide by the decision of the Administrative Law Judge ("ALJ").
2. To appeal the decision of the ALJ to the State Personnel Board ("Board"). To appeal the decision of the ALJ, a party must file a designation of record with the Board within twenty (20) calendar days of the date the decision of the ALJ is mailed to the parties. Section 24-4-105(15), C.R.S. Additionally, a written notice of appeal must be filed with the State Personnel Board within thirty (30) calendar days after the decision of the ALJ is mailed to the parties. Both the designation of record and the notice of appeal must be received by the Board no later than the applicable twenty (20) or thirty (30) calendar day deadline. Vendetti v. University of Southern Colorado, 793 P.2d 657 (Colo. App. 1990); Sections 24-4-105(14) and (15), C.R.S.); Board Rule 8-68, 4 CCR 801.
3. The parties are hereby advised that this constitutes the Board's motion, pursuant to Section 24-4-105(14)(a)(II), C.R.S., to review this Initial Decision regardless of whether the parties file exceptions.

RECORD ON APPEAL

The cost to prepare the record on appeal in this case is $50.00. This amount does not include the cost of a transcript, which must be paid by the party that files the appeal. That party may pay the preparation fee either by check or, in the case of a governmental entity, documentary proof that actual payment already has been made to the Board through COFRS. A party that is financially unable to pay the preparation fee may file a motion for waiver of the fee. That motion must include information showing that the party is indigent or explaining why the party is financially unable to pay the fee.

Any party wishing to have a transcript made part of the record is responsible for having the transcript prepared. Board Rule 8-69, 4 CCR 801. To be certified as part of the record, an original transcript must be prepared by a disinterested, recognized transcriber and filed with the Board within 59 days of the date of the designation of record. For additional information contact the State Personnel Board office at (303) 866-3300.

BRIEFS ON APPEAL

The opening brief of the appellant must be filed with the Board and mailed to the appellee within twenty calendar days after the date the Certificate of Record of Hearing Proceedings is mailed to the parties by the Board. The answer brief of the appellee must be filed with the Board and mailed to the appellant within 10 calendar days after the appellee receives the appellant's opening brief. An appellant may file a reply brief within five days. Board Rule 8-72B, 4 CCR 801. An original and 8 copies of each brief must be filed with the Board. A brief cannot exceed 10 pages in length unless the Board orders otherwise. Briefs must be double-spaced and on 8 1/2 inch by 11 inch paper only. Board Rule 8-73, 4 CCR 801.

ORAL ARGUMENT ON APPEAL

A request for oral argument must be filed with the Board on or before the date a party's brief is due. Board Rule 75, 4 CCR 801. Requests for oral argument are seldom granted.

PETITION FOR RECONSIDERATION

A petition for reconsideration of the decision of the ALJ must be filed within 5 calendar days after receipt of the decision of the ALJ. The petition for reconsideration must allege an oversight or misapprehension by the ALJ. The filing of a petition for reconsideration does not extend the thirty-calendar day deadline, described above, for filing a notice of appeal of the ALJ's decision. Board Rule 8-65, 4 CCR 801.

CERTIFICATE OF SERVICE

This is to certify that on the 30th day of June, 2006, I placed true copies of the foregoing **INITIAL DECISION OF ADMINISTRATIVE LAW JUDGE and NOTICE OF APPEAL RIGHTS** in the United States mail, postage prepaid, addressed as follows:

Teresa Zoltanski
Colorado Federation of Public Employees
1580 Logan Street, Suite 310
Denver, Colorado 80203

and in the interagency mail, to:

Roberta Lopez
Assistant Attorney General
Employment Law Section
1525 Sherman Street, 5th Floor
Denver, Colorado 80203

Jane F. Sprague
Andrea C. Woods