EXHIBIT 3
PART 3

(LOOKS LIKE ANOTHER SECTION, pg 5 sent)

6 & 7. Identify non-disabled co-workers that were similarly situated to me and treated more favorably than I was Caucasian co-worker similarly situated by treated better?

- Elizabeth Keat's (white, non-disabled English Faculty)- unethical activity was overlooked and encouraged by Dr. Kartje (see documents) when I am punished and not allowed faculty reimbursement for technicalities.
- Joel Chmara (white, non-disabled male)- not docked for missing a week of orientation (5 days) when I missed one contract day and one non-contract day and was docked hundreds of dollars.
- Many White faculty members are allowed to teach on campus during regular business hours over the summer.
- Many White, non-disabled faculty members are able to have an attendance policy without reprimand.

~~40~~

Attachment "A"

CHICAGO INSTITUTE OF
NEUROSURGERY AND NEURORESEARCH

HEALTH ASSESSMENT FORM FOR THE NEUROLOGICAL PATIENT

Please take a moment to complete this form. Completion of this form helps to provide your physician with a detailed medical history.

NAME: MARLAINA EASTON **Age:** 27 **Date:** 3·1·06

Occupation (if retired, previous occupation): College Instructor

What is the problem you would like us to help you with today?
I am having a problem w/ my multiple Sclerosis
How long have you had this problem? over a year.

B/P _____
WT _____
HT _____
___ Rt. Handed
___ Lt. Handed
___ Both
Assistive Device
___ None
___ Cane
Since ___
___ Walker
Since ___
___ Wheelchair
Since ___

LIFESTYLE :

1. Are you currently working?
X Yes ___ No
When was your last day of work?
yesterday
Amount of sitting, lifting, carrying and working overhead required by your job?
Dna
Are you currently on disability?
___ Yes X No
If *yes*, what type? _____

2. Is your problem associated with an injury? ___ Yes X No
If *yes*, when did it occur? _____
Describe the injury _____
Was the injury work related? ___ Yes ___ No
If *yes*, are you involved in any legal action or lawsuit concerning the injury, disability, or medical treatment? ___ Yes ___ No
If *yes*, Attorney's name: _____

3. What is your current level of activity?
X Normal activity, no restrictions
___ Restricted physical activity, but able to walk and do light work
___ Able to walk and get around 50% of the time; unable to work
___ Confined to chair or bed 50% of the time; need help with daily care
___ Completely disabled; unable to care for self; completely confined to chair or bed

SYMPTOM HISTORY: *Please describe your symptoms as best as you can:*
Dizziness, Depression, minor numbness

When did your symptoms first start? _____ **Was it** ___ **sudden or** X **gradual?**

Easton DEP. EX. NO 20 Reviewed by: _____
FOR ID., AS OF 9/14/09 LR

CINN 424

PAST MEDICAL HISTORY:

___ Brain Tumor ___ Lung Disease ___ Aneurysm ___ Tuberculosis ___ Diabetes
___ Arteriovenous Malformation ___ Thyroid Disease ___ Liver Disease ___ Gout ___ Ulcer
___ Bone Disease ___ Stroke ___ Arthritis
___ Hypertension ___ Heart Disease ___ Blood Disorder ___ Mental/Nervous Disorder
___ Seizure Disorder: type, if known: _____ ___ Peripheral Vascular Disease
___ Kidney/Bladder Disorder ___ Autoimmune Deficiency X Autoimmune Disease
___ Cancer (type: _____) Other: _____

MEDICATION LIST:

Name	Dose	Frequency	Name	Dose	Frequency

ALLERGIES: (such as medication, iodine, shellfish, CT infusion/IVP dye)

_____

Please describe your allergic reaction: _____

_____

FAMILY MEDICAL HISTORY: *Have your parents, grandparents, sisters or brothers had any of the following conditions? Please indicate their relationship to you including paternal/maternal when applicable:*

___ Brain Tumor ___ Lung Disease ___ Cancer (type: _____) ___ Gout
___ Aneurysm ___ Tuberculosis X Diabetes ___ Bone Disease ___ Stroke
___ Arteriovenous Malformation ___ Arthritis ___ Liver Disease ___ Hypertension ___ AVM
___ Blood Disorder ___ Ulcers ___ Mental/Nervous Disorder
___ Heart Disease ___ Seizure Disorder: type, if known _____ ___ Kidney/Bladder Disease
___ Thyroid Disease ___ Peripheral Vascular Disease ~~X~~ Autoimmune Deficiency
X Autoimmune Disease ___ Other: _____

MISCELLANEOUS INFORMATION: *Please list any of the following items that you use even on occasion:*

	How Much	How Often	How Long
Coffee			
Alcohol			
Tobacco			
Street Drugs			

Please check personal aides you use:

___ Hearing Aid ___ Glasses ___ Dentures ___ Artificial Limb
___ Other (please specify: _____)

Reviewed by: _____

What activities were you engaged in when your symptoms started? _____

If applicable, at what time of day are your symptoms worse:

___ Morning ___ Later in the day ___ During the night ___ Always the same

Frequency of symptoms:

___ Intermittent daily ___ Constant ___ Once a day ___ Once a week

___ Not applicable ___ Other (please describe): _____

If applicable, what is the character of pain:

___ Burning ___ Electric shock ___ Sharp ___ Shooting ___ Stabbing ___ Deep ache

___ Other (please describe): _____

How was this problem treated in the past? steroids

_____

Please check those that apply regarding treatment of this problem:

___ Physician (please specify: _____) ___ Chiropractor ___ Napropath

___ Doctor of Osteopathic Medicine (D.O.) ___ Physical Therapy ___ Acupuncture

___ Anesthesiologist (for injections) ___ Occupational Therapy ___ Other: _____

Have you ever had chemotherapy? ___ Yes X No

If *yes*, what hospital? _____

Have you ever had radiation therapy? ___ Yes X No

If *yes*, what hospital? _____ What part of the body? _____

HOSPITALIZATIONS AND SURGERIES: *Please list starting with the most recent:*

DATE REASON LOCATION

_____

_____

_____

_____

_____

_____

DIAGNOSTIC TESTING: *Please list any tests that you have had related to this problem:*

	CT SCAN	MRI	MYELOGRAM	ANGIOGRAM	XRAY	EMG	BONE SCAN	OTHER
BODY PART	2/24/06	Brain						
DATE	R							
PLACE								

Reviewed by: _____

ANDRA MUNTEANU, M.D.
BM 6336413
4112 N. LINCOLN AVE.
CHICAGO, ILLINOIS 60618
TEL (773) 248-0300
FAX (773) 248-0303
Office Hours By Appointment

NAME Monaunica Easton

ADDRESS

DATE 7/15/06

PHARMACY FILING NUMBER

R	mg or % sol. No. or cc.	SIG.	Rep.
1	I hereby certify that the above named		
2	patient needs a medical leave of		
3	absence for medical reasons		
4			
5			

Supply generic equivalent except # _____

M.D.

5 RECORD RECEIPT

FAMILY & MEDICAL LEAVE REQUEST FORM

NAME: Marlaina Easton	
JOB TITLE: English Instructor	
DEPARTMENT: Communication Arts	
TODAY'S DATE: 7/10/06	EMPLOYMENT DATE: June 2002 - Present

RECEIVED
JUL 17 2006
Human Resources

SECTION I – REASON FOR LEAVE

I request family or medical leave for the following reason (please check below):

☐ Because of the birth of my child.

Expected Date of Birth ___/___/___ Actual Date of Birth ___/___/___
Leave to Start ___/___/___ Expected Date of Return ___/___/___

☐ Because of the placement of a child with me for adoption.

Date of Placement ___/___/___
Leave to Start ___/___/___ Expected Date of Return ___/___/___

☐ Because of placement of a child with me for foster care.

Date of Placement ___/___/___
Leave to Start ___/___/___ Expected Date of Return ___/___/___

☐ Because I am needed to care for my spouse, child, parent (or person who resides with me) who has a serious health condition. [A physician's certification is required. Please attach.]

Name of Family Member _____
Relationship to Employee _____
Leave to Start ___/___/___ Expected Date of Return ___/___/___

☒ For a serious health condition that makes me unable to perform the functions of my position. [A physician's certification is required. Please attach.]

Describe the Condition Severe Stress Induced Symptoms And Multiple Sclerosis Intensified
Leave to Start 8/19/06 Expected Date of Return 5/15/07

Easton DEP EX. NO 23
FOR ID., AS OF 9/14/09 LK

MISCELLANEOUS

After reading each of the following statements, please initial.

ME I understand that I am ineligible for leave because of the birth or placement of a child if the birth or placement occurred one or more years ago.

ME I understand that the College may deny my request for leave until at least thirty (30) days after my request if I fail to provide timely notice of foreseeable leaves.

ME I understand that if I fail to indicate my intention to return to employment in writing, (to the Director of Human Resources) at least fourteen (14) days prior to the end of the approved leave, the College will assume that I have no intention to return to employment. In such cases, the right to my reinstatement shall cease and the employment relationship between the College and myself will be deemed terminated.

ME I understand that my right to reinstatement also ceases if I am unable to perform the essential functions of my position at the end of my leave period.

ME I understand that the College will continue to pay the premium for single medical coverage while I am on approved leave (full-time staff only).

ME I understand that I will be responsible for making timely payments to the College for the dependent portion of medical insurance premiums if I am on unpaid leave (full-time staff only).

ME I understand that the College's flexible compensation allocation shall not be continued during the period of unpaid leave (full-time staff only).

ME I understand that, if my leave does not involve a serious health condition that makes me unable to perform the functions of my position, the College may recover its share of any Premium payments for any period of unpaid leave if I fail to return to work after my leave entitlement has been exhausted (full-time staff only).

ME I understand that life insurance and disability insurance will be continued at the same level as prior to the leave (full-time staff only).

ME I understand that if I was hired into a board-established position prior to October 1, 1997 that I am currently compensated on a pre-pay basis. I also understand that upon my return from unpaid leave of absence I will be reinstated onto the payroll system and compensated on a lag-pay basis.

ME I understand that all other parameters of Policy 939 also apply.

EMPLOYEE'S SIGNATURE M. M. [illegible]	DATE 7/10/06
ADMINISTRATIVE SUPERVISOR'S SIGNATURE	DATE

CHICAGO MEDICAL CENTER, SC
4112 NORTH LINCOLN AVENUE, CHICAGO, ILLINOIS 60618
Tel 773.248.0300 / Fax 773.248.0303

February 12, 2007

Re: Marlaina Easton

To Whom It May Concern:

Ms. Easton's health has been improving remarkably with her current medical management program. If she continues to improve at this pace, as I anticipate she will, I see no reason why she would not be able to return to active employment as a full-time instructor without any restrictions for the summer session of 2007. I expect her to be fully capable to return to her full responsibilities during the summer accelerated pace without any limit to the credit hours in her summer schedule load. The only special requirement she will have is access to air conditioning.

Dr. Munteanu

Karen,
I gave Tom original – Came to his attn – Kept a copy for us!
Cathy

www.chilisjobs.com

Easton DEP. EX. NO 24
FOR ID., AS OF 9/14/09 LR

faxed 2/14/07 2:14 pm, called @ 2:41 pm, informed that it was rece
THOMAS P. Heinrich (HR) Fax # (847) 223-0824

College of Lake County

Human Resources

VOICE
(847) 543-2065
FAX
(847) 223-0824
E-MAIL
personnel@clcillinois.edu
WEBSITE
www.clcillinois.edu

VIA CERTIFIED MAIL

August 11, 2006

Marlaina Easton
6315 N. Magnolia, 2S
Chicago, IL 60660

Dear Ms. Easton:

Per our brief telephone conversation yesterday, I have attached completed "employer sections" of the disability application form for you to include with the other sections of the disability application form.

As you will note, according to our records, you may remain in "pay status" with full pay through October 24, 2006. This projection assumes that you will continue to be medically disabled through this period of time, and that you use all of your 51 remaining health leave days.

In closing, please allow me to express our sincere wishes for your speedy and thorough recovery. Please do not hesitate to contact me with any questions or concerns.

Sincerely,

Thomas P. Heinrich
Director of Human Resources

Attachments

CC: File

11-6-06 - It was determined that Marlaina actually had 67 health leave days w/ PS adjustment + FY accrual. cac

Easton DEP. EX. NO 25
FOR ID., AS OF 9/14/09 cr

State Universities Retirement System **APPLICATION FOR DISABILITY** **1**
The Prudential Insurance Company of America (if applicable)

EMPLOYER SECTION - PART 1 (Please print in **BLACK INK**)

1. Name of Employer: COLLEGE OF LAKE COUNTY
2. Name of Employee: MARLAINA EASTON
3. S.S.# ____ ____ 1
4. Last day worked: 7 / 30 / 06
5. Date disability occurred: 8 / 14 / 06
6. Last day paid: 10 / 29 / 06 *
   * projection
7. Dates of last payroll period: ____/____/____ to 10 / 29 / 06
8. Is the employee able to perform the duties of his/her position? Yes☐ No☒
   (This is required from the Employer by SURS Statutes under eligibility)
9. Basic monthly rate of earnings **(as of the last day worked)** $ 7314.44
   Effective date of basic monthly rate of earnings: 7 / 1 / 06
   Monthly basis: ☒9 Months ☐12 Months ☐Other ____
   Percent time of position: 100 % ☒Academic ☐Staff Support
10. Is claimant enrolled in the Prudential LTD plan? Yes☐ No☒
    If yes, what was his/her date hired: ____/____/____ Policy #____
11. Have you and the claimant discussed reasonable accommodations which would allow a return to work or would have allowed him/her to continue working? Yes☐ No☒
    Explain: ____
12. If recovered, has claimant returned to work? Yes☐ No☐ When? ____/____/____ Not applicable
13. Did this disability occur as a result of claimant's employment? Yes☐ No☒ Disputed☐
    If YES, or under dispute, please provide policy #, name, address, and phone # of Workers' Compensation administrator. ____
14. To the best of your knowledge, is the claimant receiving or entitled to receive benefits from any of these sources?
    Salary Continuance? Yes☐ No☒ Amount $____ Per____
    From ____/____/____ to ____/____/____
    Workers' Comp? Yes☐ No☒ Weekly Benefit $____ Effective ____/____/____
    Employer-Paid Insurance Contract? Yes☐ No☒
    Amount $____ Per ____ From ____/____/____ to ____/____/____
    Other? Yes☐ No☒ ____
15. Authorized signature & title of employer representative completing this section:
    Thomas R Jennrich — Signature
    Director of Human Resources — Title
    (847) 543-2215 — Phone
    (847) 223-0824 — Fax
    8/10/06 — Date

State Universities Retirement System **APPLICATION FOR DISABILITY** **2**
The Prudential Insurance Company of America (if applicable)

EMPLOYER SECTION - PART 2 (Please print in **BLACK INK**)
(Physical/Nonphysical aspects of job - To be completed by employee's Supervisor)

Supervisor's Signature/Title: J Ballard VP Educational Affairs Date 8 / 11 / 08

Employee's Name/Occupation: MARLAINA EASTON - ENGLISH INSTRUCTOR

1. In a typical workday, how many hours does claimant spend in each position, and can he/she alternate positions?

Position	Total no. of hours	May Alternate Positions: At will	15-30 Minutes	Hourly	Never
Sitting	_____	☒	☐	☐	☐
Standing	_____	☒	☐	☐	☐
Walking	_____	☒	☐	☐	☐
Driving	_____	☐	☐	☐	☒

2. Claimant must

		Never	Occasionally (¼ -2 ½ hours)	Frequently (2 ½ -5 ½ hours)	Continuously (5 ½ -8 hours)
A.	Bend/Stoop	☐	☒	☐	☐
B.	Climb	☒	☐	☐	☐
C.	Reach above shoulder level	☐	☒	☐	☐
D.	Kneel	☒	☐	☐	☐
E.	Balance	☐	☒	☐	☐
F.	Enter data/keystroke	☐	☒	☐	☐
G.	Squat	☒	☐	☐	☐
H.	Crawl	☒	☐	☐	☐
I.	Crouch	☒	☐	☐	☐
J.	Lift Usual 5 lbs.	☐	☒	☐	☐
	Max 15 lbs.	☐	☒	☐	☐
K.	Carry Usual 5 lbs.	☐	☒	☐	☐
	Max 15 lbs.	☐	☒	☐	☐
L.	Push/Pull Usual — lbs.	☒	☐	☐	☐

3. On the job, claimant uses feet for repetitive movements as in operating foot controls.
Right: ☐ Yes ☒ No Left: ☐ Yes ☒ No Both: ☐ Yes ☒ No

4. On the job, claimant uses hands for repetitive action such as:

	Simple Grasping	Firm Grasping	Fine Manipulation
A. Right	☒	☒	☒
B. Left	☒	☒	☒

5. Does job require:
A. Working at heights? ☐ Yes ☒ No
B. Exposure to marked changes in temperature & humidity or extremes thereof?
☐ Yes ☒ No
C. Exposure to dust, fumes, gases, chemicals? ☐ Yes ☒ No

6. Stress/Nonphysical
Stress level of position is: ☐ Low ☒ Medium ☐ High
☐ Occasionally ☐ Frequently ☐ Continuously

State Universities Retirement System of Illinois
Serving Illinois Community Colleges and Universities
1901 Fox Drive • Champaign, IL 61820-7333
1-800-ASK SURS
(217) 378-9800 (FAX)
(217) 378-8800 (C-U)
www.surs.org

June 11, 2007

Ms. Marlaina Easton
6315 N Magnolia Ave # 2S
Chicago, IL 60660-1405

RECEIVED
JUN 13 2007
Human Resources

RE: Disability Application
Member ID#: 1106780

Dear Ms. Easton:

Your disability claim has been reviewed by the State Universities Retirement System and has been denied due to ineligibility for the following reason(s):

The requested therapy notes were never received.

STAFF DETERMINATION
You may file a written request for review with SURS Deputy Director of Member Services at the address shown above if you believe this decision is incorrect. This request must be filed **within 30 days** from the date of this letter. If you fail to file a request **within 30 days**, the decision will become final because you elected not to seek administrative review of the decision.

If you have any questions concerning this matter, please contact a SURS Benefits Counselor at 1-800-275-7877 or 217-378-8800 in the Champaign-Urbana area.

Sincerely yours,

Denise Shelton

Denise Shelton
Medical Claims Processor

cc: ✓ Ms. Karen Dawson
College of Lake County
19351 W Washington St
Grayslake, IL 60030-1148

Easton Dep. Ex. No. 26

DIS10

UDKS

College of Lake County

Human Resources
VOICE
(847) 543-2065
FAX
(847) 223-0824
E-MAIL
personnel@clcillinois.edu
WEBSITE
www.clcillinois.edu

CONFIDENTIAL
ADDRESSEE ONLY
VIA CERTIFIED AND REGULAR MAIL

December 6, 2006

Marlaina Easton
6315 N. Magnolia, 2S
Chicago, IL 60060

Dear Ms. Easton:

As you know, last summer you provided the College with medical documentation indicating that you should be off of work through May 2007. Nevertheless, as the College is completing its staffing for next semester, we wanted to verify that this medical assessment is still accurate.

Please inform me, in writing by December 15, 2006, if your medical condition has changed and you intend to resume work for the Spring Semester 2007. If I do not hear from you by December 15, 2006, I will assume that you are unable to return and we will go about making alternate arrangements.

Once again, please accept my best wishes for a full and speedy recovery. Please feel free to contact me with any questions or concerns.

Sincerely,

Thomas P. Heinrich
Director of Human Resources

CC: D. Pollard
J. Kartje
Personnel File

Easton DEP. EX. NO 27
FOR ID., AS OF 10/5/09 cr

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF ILLINOIS
EASTERN DIVISION

MARLAINA EASTON,

Plaintiff,

v.

COLLEGE OF LAKE COUNTY,
Dr. Jean Kartje and Board of Trustees
Of the College of Lake County,

Defendants.

07CV 6127
JUDGE DARRAH
MAGISTRATE JUDGE BROWN

Complaint

JFI

Jury Demanded

I. JURISDICTION

1. This is an action seeking money damages and other relief for discrimination based upon race, national origin, disability and for retaliation.

2. The jurisdiction of this Court is invoked pursuant to the Constitution of the United States and 42 U.S.C. §1983, 42 U.S.C. §1981, 42 U.S.C.§2000e, et seq., 42 U.S.C. §12001 et seq.

3. The rights, privileges and immunities sought herein to be redressed are those secured by the equal protection and due process clauses of the Fourteenth Amendment of the United States Constitution, 42 U.S.C. §1981 and 1983 and provisions against racial discrimination pursuant to Title VII of the Civil Rights Act of 1964.

4. Plaintiff also invokes this Court's pendant jurisdiction of her claim pursuant to Illinois State law. More specifically, Plaintiff alleges that the Defendants have violated her rights to due process and equal protection as guaranteed her by the Illinois State Constitution. It is further claimed that Defendants have violated 775 ILCS 5/1-101 et seq.

5. Plaintiff has exhausted her administrative remedy.

II. PARTIES

1. Plaintiff, MARLAINA EASTON, ("Marlaina") is an Afro-American/Hispanic female, whose national origin is Puerto Rico and who, at all times relevant hereto, suffered from Multiple Sclerosis ("MS"). She is a United States citizen and resides in the State of Illinois.
2. Marlaina has been employed as an English professor with the College of Lake County ("College") since June 2001.
3. The College is comprised of a faculty and students from primarily Caucasian upper middle class backgrounds.
4. Defendant, ("College"), is a state owned and operated college in Grayslake, Illinois.
5. Defendant, Dr. Jean Kartje, ("Dean"), on or about the time complained of, was the Dean of Communication Arts at the College and was the direct supervisor of Marlaina.
6. Defendant, Board of Trustees, College of Lake County ("Board"), is the governing body of the College.

III. FACTS

7. On or about 2001, Marlaina was hired by the College as an English Professor in the Communication Arts Division.
8. Between 2001 and 2003, the Dean of Communication Arts was Dr. Sandria Rodriguez ("Sandria"), who had hired Marlaina.
9. During the period between 2001 and 2003, Marlaina had excellent evaluations, peer reviews and student evaluations, and was recognized for her substantial efforts in working

with Developmental students of color and students with disabilities.

10. Marlaina, during this period, worked with faculty members to improve their own classes concerning these students and taught summer classes where she was able to teach and influence such students.

11. During this period, Marlaina, notwithstanding her MS disability, which she suffered from since childhood, was able to function, as a productive and energetic member of the college teaching community.

12. During this period, Marlaina was able to keep the effects of her MS illness under control and at no time exceeded the permitted sick or absent days allowed under her contract.

13. During this period, Marlaina was on a tenure track which she was scheduled to achieve during the year 2004.

14. On or about August 2004, Defendant, Dean, was employed by the College as Dean of the Communications Arts Division and as such was placed in direct supervisory and administrative control of Marlaina.

15. During the period between August 2004 and July 2006, when Defendant, Dean was terminated as an employee of the College, said Dean engaged in the following acts of harassment and discrimination against Marlaina without any cause or justification:

a. She docked Marlaina's pay without cause or justification for a justifiable absence while allowing white, non-disabled teachers in her division to have absences without docking their pay.

b. She constantly accused Marlaina of excessive absenteeism, even though Marlaina's absent days were not excessive by any standards of the College or