State of Alaska
Department of Administration
Division of Personnel & Labor Relations
PO Box 110201
Juneau, AK 99811-0201

Conditional Family Leave Notification

It is State of Alaska policy to invoke family leave for all qualifying conditions. The supervisor or designee is responsible for initially identifying a qualifying condition and for notifying an employee of his/her conditional family leave entitlement.

Employee Name _____ Employee ID _____ Dept _____

A. Information obtained from:

☐ Employee
☐ Employee's spokesperson
☐ Certification of Health Care Provider (if available)

B. Leave is requested for:

☐ Employee's serious health condition
☐ Employee's spouse, child or parent's serious health condition
☐ Birth of or placement for adoption of a child (Skip to G)
☐ Placement for foster care of a child (Skip to G)
☐ Pregnancy (Skip to G)

C. What is the Condition? _____

D. Identify the basis for determining the serious health condition:

☐ Hospital Care (Inpatient)
☐ Pregnancy/Prenatal
☐ Permanent/Long-term Conditions Requiring Treatment
☐ Absence Plus Treatment
☐ Chronic Conditions Requiring Treatment
☐ Multiple Treatments (Non-Chronic Conditions)
☐ Unknown

E. Does the employee or an employee's family member's condition(s) require the employee to be absent from work due to treatment or incapacity? ☐ Yes (Check Treatment or Incapacity) ☐ No ☐ Unknown

☐ Treatment - The employee must be absent from work for intermittent, part-time, or a regimen of treatment.
☐ Incapacity - The employee must be absent from work due to incapacity or episodes of incapacity or need to work on an intermittent or reduced schedule.

F. Light Duty: The employee's health care provider has certified that the employee is able to perform light duty; the appointing authority has determined the light duty is available; and the employee has volunteered to perform the light duty.

Estimated duration of temporary light duty assignment: _____

G. Determination:

As the Supervisor/Designee, I have conditionally invoked family leave for this employee as of _____ pending receipt and/or review of "Certification of Health Care Provider" form by the Payroll Services of the Division of Personnel & Labor Relations. A copy of this notification and the family leave packet was supplied to the employee. It is understood that a final determination requires the receipt of a completed "Certification of Health Care Provider." The Payroll Services section will provide final determination notification to the employee and to the supervisor.

On _____ the Supervisor/Designee distributed the Certification of Health Care Provider (CHCP) Form to the employee.

Comments if any:

Supervisor/Designee Signature _____ Date_____

Supervisor/Designee Printed Name_____ Telephone _____

Fax or send this form with any attachments to your agency's Payroll Services office. Please contact your agency's Payroll Services office with any questions. (Contact numbers available at http://dop.state.ak.us/)

Distribution: Original: Employee Copy: Payroll Services, Division of Personnel & Labor Relations

*Note - Definitions are located on the reverse of the Certification of Health Care Provider form.

Revised 04/20/2012

State of Alaska
Division of Personnel & Labor Relations
PO Box 110201
Juneau, Alaska 99811-0201

YOUR RIGHTS UNDER THE FAMILY AND MEDICAL LEAVE ACT OF 1993 and ALASKA FAMILY LEAVE ACT OF 1992

THE FAMILY AND MEDICAL LEAVE ACT (FMLA) requires covered employers to provide up to 12 weeks of paid or unpaid, job-protected leave to eligible employees for certain family and medical reasons (the State of Alaska is a covered employer). Employees are eligible if they have worked for a covered employer for at least one year, and for 1,250 hours over the previous 12 months, and if there are at least 50 employees within 75 miles.

THE ALASKA FAMILY LEAVE ACT (AFLA) requires covered public employers to provide up to 18 weeks of paid or unpaid, job-protected leave to eligible employees for certain family and medical reasons. Employees are eligible if they have been employed for a covered employer for at least 35 hours a week for at least six consecutive months or for at least 17.5 hours a week for at least 12 consecutive months immediately preceding the leave, and if there have been at least 21 employees within 50 road miles during any period of 20 consecutive workweeks in the preceding two calendar years.

POLICY: The State of Alaska has elected to substitute paid leave for unpaid leave for use in a family leave qualifying condition when it is available to the employee through accruals, donations, or other means authorized by collective bargaining agreements or state statutes. The State of Alaska has adopted a more generous policy that allows employees who meet the employment and hours worked thresholds to be eligible for family leave regardless of the number of employees within a given radius.

REASONS FOR TAKING LEAVE: Either or both of these leave entitlements require an absence to be granted for any of the following reasons:

- to care for the employee's child after birth, or placement for adoption or foster care; or
- to care for the employee's spouse, son or daughter, or parent (in-law, step, or who stood in loco parentis) who has a serious health condition; or
- for a serious health condition that makes the employee unable to perform the employee's job.

ADVANCE NOTICE AND MEDICAL CERTIFICATION: The employee may be required to provide advance leave notice and medical certification. Taking of leave may be denied if requirements are not met.

- The employee ordinarily must provide 30 days advance notice when the leave is foreseeable.
- An employer may require medical certification to support a request for leave because of a serious health condition, and may require second or third opinions (at the employer's expense), periodic updates, and a fitness for duty report to return to work.

JOB BENEFITS AND PROTECTION:

- For the duration of FMLA leave, the employer must maintain the employee's health coverage under any group plan. There is no similar requirement under AFLA.
- Upon return from FMLA or AFLA leave, most employees must be restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms.
- For the use of family leave, an employee cannot realize the loss of any employment benefit that accrued prior to the start of an employee's leave.

UNLAWFUL ACTS BY EMPLOYERS: The Family Leave Acts makes it unlawful for any employer to:

- interfere with, restrain, or deny the exercise of any right provided under the Acts.
- discharge or discriminate against any person for opposing any practice made unlawful by the Acts or for involvement in any proceeding under or relating to the Acts.

ENFORCEMENT:

- Employees covered by a collective bargaining agreement may follow the complaint procedure set out in their respective agreements.
- The U.S. Department of Labor is authorized to investigate and resolve complaints of violations of FMLA. The Alaska Department of Labor is authorized to investigate and resolve complaints of violations of AFLA.
- An eligible employee may bring civil action against an employer for violations of either family leave Act. The Acts do not affect any Federal or State law prohibiting discrimination, or supersede any State or local law or collective bargaining agreement which provides greater family or medical leave rights.

FOR ADDITIONAL INFORMATION: Contact your agency Human Resource Office, or the nearest office of the Wage and Hour Division, listed in most telephone directories under U.S. Government, Department of Labor.

DOP-50003-090701

State of Alaska
Division of Personnel & Labor Relations
PO Box 110201
Juneau, AK 99811-0201

CERTIFICATION OF HEALTH CARE PROVIDER

Section A: Employee/Patient Information

Employee's Name (First, Last, MI):	Patient's Name:	Relationship of Patient to Employee: ☐ Self ☐ Parent ☐ Spouse ☐ Dependent Child (Child's Age)
Employee's Dept:	List any relative working in same dept and the relationship to employee:	

To be completed by person needing family leave to care for a family member. Attach a description of the care to be provided and estimate the time period for which it will be necessary, including a schedule if leave will be taken intermittently or on reduced leave schedule.

Signature of Employee: Work #: Home #: Date:

Release of Medical Information: I authorize the release of any medical information necessary to provide the information requested on this form.

Signature of Patient: Date:

Section B: Completed by Health Care Provider

1. Indicate the appropriate category of Serious Health Condition:
   a. ☐ Hospital Care (definitions on reverse of form)
   b. ☐ Absence Plus Treatment
   c. ☐ Pregnancy/Prenatal
   d. ☐ Chronic Conditions Requiring Treatment
   e. ☐ Permanent/Long-term Conditions Requiring Treatment
   f. ☐ Multiple Treatments (Non-Chronic Conditions)

2. Please describe the **medical facts** supporting your certification:

4a. Date condition commenced and probable duration:

4b. Date(s) of patient's **present incapacity** (if different from 4a):

5. NOTE: Please indicate type of absence requested:
   Continuous: give duration of time off work:_____
   Intermittent/Reduced Schedule: please estimate episodic absences based upon patient's past history:
   Frequency of episodes:_____
   Duration of episodes:_____

6. Prescribed treatment regimen and schedule:
   Office visits: #_____per_____
   Therapy visits: #_____per_____
   Prescription medication:_____
   Referral to other providers (who)_____
   Surgery (date):_____
   Procedure (type/date):_____
   Other treatments (type/dates):_____

EMPLOYEE'S OWN SERIOUS HEALTH CONDITION:

7. Is in-patient hospitalization of the employee required? ☐ Yes ☐ No (give dates)_____

8. Is employee able to perform work of any kind? ☐ Yes ☐ No

9a. Is employee able to perform the functions of employee's position? ☐ Yes ☐ No

9b. If not, please describe employee's restrictions (include need for reduced work schedule) and their duration:
Restrictions:

Duration:

FAMILY MEMBER'S SERIOUS HEALTH CONDITION:

10. Will the patient require assistance for basic medical, hygiene, nutritional, safety or transportation needs? ☐ Yes ☐ No

11. After review of the employee's signed statement above, is the employee's presence necessary or would it be beneficial for the care of the patient? (This may include psychological comfort.) ☐ Yes ☐ No

12. Estimate the period of time care is needed or the employee's presence would be beneficial to care for the patient.

Type of Practice (Field of specialization, if any):	Address of Health Care Provider:
Print name of Health Care Provider:	Office Telephone #:
Health Care Provider Signature:	Date Signed:

State of Alaska
Division of Personnel & Labor Relations
PO Box 110201
Juneau, AK 99811-0201

CERTIFICATION OF HEALTH CARE PROVIDER

Family and Medical Leave Information Sheet

For purposes of family leave, **"serious health condition"** means an illness, injury, impairment, or physical or mental condition that involves one or more of the following:

1. **Hospital Care Inpatient care** [1] (*i.e.*, an overnight stay) in a hospital, hospice, or residential medical care facility, including any period of incapacity or subsequent treatment in connection with or consequent to such inpatient care.

2. **Absence Plus Treatment** A period of incapacity of **more than three consecutive calendar days** (including any subsequent treatment or period of incapacity relating to the same condition), that also involves:
   (1) **Treatment** [2] **two or more times** within 30 days of the first day of incapacity by a health care provider, by a nurse or physician's assistant under direct supervision of a health care provider, or by a provider of health care services (*e.g.*, physical therapist) under orders of, or on referral by, a health care provider; *or*
   (2) **Two visits for treatment** by a health care provider which results in a **regimen of continuing treatment** [3] **under the supervision of the health care provider**.

3. **Pregnancy/Prenatal Care**
   Any period of incapacity due to **pregnancy**, or for **prenatal care**.

4. **Chronic Conditions Requiring Treatments**
   A **chronic condition** which:
   (1) Requires **at least two visits annually** for treatment by a health care provider, or by a nurse or physician's assistant under direct supervision of a health care provider;
   (2) Continues over an **extended period of time** (including recurring episodes of a significant underlying condition); and
   (3) May cause **episodic** rather than a continuing period of incapacity (*e.g.*, asthma, diabetes, epilepsy, etc.)

5. **Permanent/Long-Term Conditions Requiring Supervision**
   A period of **incapacity** which is **permanent or long-term** due to a condition for which treatment may not be effective. The employee or family member must be **under the continuing supervision of, but need not be receiving active treatment by, a health care provider**. Examples include Alzheimer's, a severe stroke, or the terminal stages of a disease.

6. **Multiple Treatments (Non-Chronic Conditions)**
   Any period of absence to receive **multiple treatments** (including any period of recovery there from) by a health care provider or by a provider of health care services under orders of, or on referral by, a health care provider, either for **restorative surgery** after an accident or other injury, **or** for a condition that **would likely result in a period of incapacity of more than three consecutive calendar days in the absence of medical intervention or treatment**, such as cancer (chemotherapy, radiation, etc.), severe arthritis (physical therapy), or kidney disease (dialysis).

For purposes of family leave, **Incapacity** means a period of incapacity (i.e., inability to work, attend school or perform other regular daily activities due to the serious health condition, treatment therefore, or recovery there from.)

Light Duty is defined as a temporary modification or elimination of one or more of the essential function(s) of the position. (For questions, please contact your Agency Human Resource Office.)

[1] Here and elsewhere on this form, the information sought relates only to the condition for which the employee is taking FMLA leave.

[2] Treatment includes examination to determine if a serious health condition exists and evaluation of the condition. Treatment does not include routine physical examinations, eye examinations, or dental examinations.

[3] A regimen of continuing treatment includes, for example, a course of prescription medication (e.g., an antibiotic) or therapy requiring special equipment to resolve or alleviate the health condition. A regimen of treatment does not include the taking of over-the-counter medications such as aspirin, antihistamines, or salves, or bed-rest, drinking fluids, exercise, or other similar activities that can be initiated without a visit to a health care provider.