E 4161.4/4261.4/4361.4 FAMILY MEDICAL LEAVE

REQUEST, APPROVAL & NOTICE OF DESIGNATION

This form is to be utilized by employees for leave requests under the federal Family and Medical Leave Act (FMLA) and Alaska's Family Leave Act (AFLA)

SECTION 1: Family and Medical Leave Request – to be completed by the employee (or the supervisor if the employee is unavailable or unable to complete the form)

This Family and Medical Leave of Absence is for the following **qualifying reason**:

☐ Due to birth of a child and/or to care for a newborn child of the employee OR placement of a child with the employee through adoption or foster care

- If leave is requested for adoption: child ☐ is, ☐ is not the employee's step-child

☐ Due to the employee's serious health condition

☐ Due to a covered servicemember with a serious injury or illness who is the ☐ spouse, ☐ child, ☐ parent or ☐ next of kin of an employee

☐ Due to care of the employee's ☐ spouse, ☐ child, ☐ parent who has a serious health condition

☐ Due to a qualifying exigency arising out of the fact that the employee's ☐ spouse, ☐ child, ☐ parent is on active duty or call to active duty status in support of a contingency operation as a member of the National Guard or Reserves

***A medical certification will be required for all leave requests for a serious health condition of the employee or the employee's spouse, child, or parent*.**

Employee requests ☐ full-time leave, ☐ intermittent or reduced-schedule leave on the following schedule: _____

for the following reason:_____.

Anticipated date FMLA leave is to begin _____ to end _____ (if known)

- Employee ☐ does, ☐ does not have a spouse employed by the District: _____ (name),_____ _____ (position)
- Employee's primary job is to teach and instruct students: ☐ Yes ☐ No

Employee Staff ID #:_____ **Employee's Department or Position** _____

_____ _____

Employee full name (please print) **Date**

_____

Employee Signature

SECTION 2: FMLA/AFLA Time Designation – to be completed by the EMPLOYEE:

- The District requires employees to use all applicable paid leave accruals during family and medical leave. This means that you will receive your paid leave and the leave will also be considered FMLA/AFLA leave and counted against your leave entitlement.
- **Please designate the order** of using paid time off:

____ Annual Leave ____ Sick Leave

SECTION 3: To be completed by the DISTRICT. Return a completed copy of this form to the employee within <u>five business days</u> of the employee notifying the district of the need for family and medical leave.

☐ Leave of absence ***approved*** for birth or care of child, or placement of child: ☐ FMLA eligibility met ☐ AFLA eligibility met

☐ Leave of absence ***approved*** due to a qualifying military exigency (FMLA eligibility met)

☐ Leave of absence ***conditionally approved*** pending receipt of certification: ☐ FMLA eligibility met ☐ AFLA eligibility met

Certification due by _____ (allow at least 15 calendar days)

☐ Certification provided is not complete or sufficient to determine whether FMLA or AFLA applies. You must provide further information no later than _____ (allow at least calendar 7 days) or your leave may be delayed or denied. Information needed to make the certification complete and sufficient is:

_____

_____

☐ Certification was received on _____ (date), and we are exercising our right to have you obtain a second or third medical certification at our expense. You will be contacted with further details.

☐ Certification was received on _____ (date), has been reviewed and **<u>final approval</u>** is granted. All leave taken for this reason will be designated as ☐ FMLA leave, ☐ AFLA leave, ☐ both FMLA and AFLA leave.

☐ Leave of absence ***denied*** because:

- ☐ Employee does not qualify for FMLA leave:
  - ☐ has not been employed by the District for 12 months (does not need to be continuous), only _____ months have been worked
  - ☐ has not worked 1,250 actual hours in the past 12 months prior to this leave, only _____ hours have been worked
- ☐ Employee does not qualify for AFLA leave:
  - ☐ has not been employed for at least 35 hours a week for the past 6 months, or for at least 17.5 hours a work for the past 12 months, only _____ hours have been worked over _____ months.
- ☐ Employee did not provide supporting certification
- ☐ Employee's allotment of FMLA/AFLA has been exhausted
- ☐ Employee's leave request does not qualify for FMLA/AFLA leave

District Point of Contact (Name and number)

Signature **Date**

If you have any questions, contact the District representative identified above or review the District's family and medical leave policy and regulations, BP/AR 4161.4. These can be obtained from your supervisor, the District office, or on the District's website.

SECTION 4: Employee Responsibilities

If your leave has been approved, you will have the following **responsibilities**:

- Contact _____ at _____ to make arrangements to continue to make your share of the premium payments on your health insurance to maintain health benefits while you are on leave. The amount of your premium payment will depend upon whether your leave is under FMLA, AFLA, or both. You have a minimum 30-day (or, indicate longer period, if applicable) grace period in which to make premium payments. If payment is not timely made, your group health insurance may be cancelled, provided we notify you in writing at least 15 days before the date that your health coverage will lapse, or, at our option, we may pay your share of the premiums during leave, and recover these payments from you upon your return to work.
- If you do not return to work following leave for a reason other than: 1) the continuation, recurrence, or onset of a serious health condition which would entitle you to leave; 2) the continuation, recurrence, or onset of a covered servicemember's serious injury or illness which would entitle you to FMLA leave; or 3) other circumstances beyond your control, you may be required to reimburse us for our share of health insurance premiums paid on your behalf during your FMLA or AFLA leave.
- While on leave you will be required to furnish us with periodic reports of your status and intent to return to work every ____ _____. (Indicate interval of periodic reports, as appropriate for the particular leave situation).
- **If the circumstances of your leave change, and you are able to return to work earlier than the date indicated on this form, you will be required to notify us at least two workdays prior to the date you intend to report for work.**
- **You are required to notify us as soon as practicable if dates of scheduled leave change or are extended, or were initially unknown. Based on the information you have provided to date, we are providing the following information about the amount of time that will be counted against your leave entitlement:**

  ☐ Provided there is no deviation from your anticipated leave schedule, the following number of hours, days, or weeks will be counted against your leave entitlement:_____

  ☐ Because the leave you will need will be unscheduled, it is not possible to provide the hours, days, or weeks that will be counted against your FMLA/AFLA entitlement at this time. You have the right to request this information once in a 30-day period (if leave was taken in the 30-day period).

- If you have taken leave for your own serious health condition, you will be required to present a fitness-for-duty certificate to be restored to employment. If such certification is not timely received, your return to work may be delayed until certification is provided. A list of the essential functions of your position ☐ **is,** ☐ **is not** attached. If attached, the fitness-for-duty certification must address your ability to perform these functions.

E 4161.4(d)
4261.4(d)
4361.4(d)

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
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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 the Division of Personnel & Labor Relations Management Services Section.)

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[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.

DOP-50001-090701 Revised 7/01/2009

Added 3/2012