Department of Administration

DIVISION OF PERSONNEL AND LABOR RELATIONS
PAYROLL SERVICES

801 W. 10th Street, Suite B OR 550 W. 7th Avenue, Suite 1660
Juneau, Alaska 99801 Anchorage, AK 99501

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
Qualifying military exigency (Skip to H)
Birth of or placement for adoption of a child (Skip to H)
Placement for foster care of a child (Skip to H)
Pregnancy (Skip to H)
Covered servicemember's serious illness or injury (Skip to H)

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. Fitness for Duty: When the Supervisor/Designee believes a fitness for duty report is necessary prior to the employee returning to work, the Supervisor/Designee must contact their agency Human Resource Office for a final determination.

H. Determination:
As the Supervisor/Designee, I have conditionally invoked family leave for this employee as of (Date)_____________ pending receipt and/or review of the "Certification of Health Care Provider" (CHCP) form (or applicable military form) by Payroll Services of the Division of Personnel & Labor Relations. A copy of this notification and the family leave packet (or military family leave packet) was supplied to the employee on (Date)_________. Payroll Services will determine if employee meets employment thresholds, which are required to qualify for family leave. It is understood that a final determination requires the receipt of a completed CHCP form (or applicable military form). Payroll Services will provide final determination notification to the employee and to the supervisor.
Note: Employee must return the CHCP (or applicable military form) to the Payroll Services office within 15 days of the distribution date.

Comments if any: ____

Supervisor/Designee Signature ____________________________________ Date___________________

Supervisor/Designee Printed Name____________________________________ Telephone _______________

Promptly send this form with any attachments to Payroll Services. Please contact the Payroll Services office with any questions. (Contact numbers available at: http://doa.alaska.gov/dop/fileadmin/ServiceCenter/PayrollContactList.pdf)

Distribution: Original: Employee Copy: Payroll Services

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

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YOUR RIGHTS AND RESPONSIBILITIES 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 in a 12 month period of paid or unpaid, job-protected leave to eligible employees for qualifying 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 (see the policy below concerning the number of employees within a given radius).

THE ALASKA FAMILY LEAVE ACT (AFLA) requires covered public employers to provide up to 18 weeks in a 12 or 24 month period of paid or unpaid, job-protected leave to eligible employees for qualifying family and medical reasons. Employees are eligible if they have been employed by 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 (see the policy below concerning the number of employees within a given radius).

MILITARY FAMILY LEAVE (MFL) is a FMLA amendment, which includes 2008 and 2010 provisions, that has the same eligibility requirements and job protection provided by FMLA. This amendment allows an employee to take up to 12 weeks of leave in a 12 month period for "any qualifying exigency" of a military member who is on covered active duty and is a qualified family member. This amendment also allows an employee to take up to 26 weeks of leave in a 12 month period to care for a covered servicemember (qualified family member) recovering from a serious illness or injury sustained in the line of duty while on active duty. A "covered servicemember" is defined as a member in the Armed Forces (including the National Guard or Reserves) or a veteran who was active in the Armed Forces within the last five 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 chosen to have the 12 or 24 month family leave entitlement start when an employee first takes leave for the qualifying condition. 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:
º to care for the employee's child after birth, or placement for adoption or foster care; or
º 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
º for a serious health condition that requires the employee to be absent from the employee's job; or
º for an employee whose family member is a military member who has a qualifying exigency or a serious illness or injury.

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.
º The employee ordinarily must provide 30 days advance notice when the leave is foreseeable (notification can be provided by a family member or spokesperson when necessary).
º When leave is not foreseeable, the employee must provide notice as soon as reasonably possible.
º 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/or a fitness for duty report to return to work.

JOB BENEFITS AND PROTECTION:
º 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.
º 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.
º 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.

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EMPLOYEE RESPONSIBILITIES:

- When medical certification is required, the employee must return the completed form to Payroll Services within 15 days of receiving notice from employer. If the certification is not received, the employee may be denied coverage under the family leave acts.
- The employee is responsible for their portion of premium payments for health insurance and other optional benefits. Premiums are taken as payroll deductions but if funds become insufficient the employee will need to make arrangements to pay premiums.
  Note: Certain optional benefits will stop if there are insufficient funds for payroll deductions. Contact Payroll Services for more information.
- When an employee takes leave, associated with the covered condition(s), notification must be given to the supervisor and "family leave" must be noted on the leave slip.
- The employee must follow the agency's leave notification requirements including established call-in procedures.
- All leave designated as family leave will count against the employee's family leave entitlements.
- When a fitness for duty report is required, it must be provided as requested prior to the employee returning to work.
- With rare exception, an employee who does not return to work for at least 30 days will be required to reimburse the State of Alaska's portion of the health insurance premiums for the period of time the employee was on family 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, Payroll Services or the nearest office of the Wage and Hour Division, listed in most telephone directories under U.S. Government, Department of Labor.

Links to Additional Information:

- Payroll Services Contact List - http://doa.alaska.gov/dop/fileadmin/ServiceCenter/PayrollContactList.pdf
- Family Leave Information for State of Alaska Employees – http://doa.alaska.gov/dop/serviceCenters/familyLeave/

Certification of Qualifying Exigency For Military Family Leave (Family and Medical Leave Act)

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

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

SECTION I: FOR COMPLETION BY THE SUPERVISOR

INSTRUCTIONS to the SUPERVISOR: The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA leave due to a qualifying exigency to submit a certification. Please complete Section I before giving this form to your employee. You may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. § 825.309. This form complies with this requirement and the use of this form is encouraged.

Supervisor name: Contact Information:

SECTION II: FOR COMPLETION BY THE EMPLOYEE

Name of Employee: Department:

Employee ID Number:

Please complete fully and completely. The FMLA permits an employer to require that you submit a timely, complete, and sufficient certification to support a request for FMLA leave due to a qualifying exigency. Be as specific as you can; terms such as "unknown," or "indeterminate" may not be sufficient to determine FMLA coverage. Your response is required to obtain a benefit. 29 C.F.R. § 825.310. While you are not required to provide this information, failure to do so may result in a denial of your request for FMLA leave. Your employer must give you at least 15 calendar days to return this form to your employer.

Name of covered military member on active duty or call to active duty status in support of a contingency operation:

Relationship of covered military member to you:

Period of covered military member's active duty:

A complete and sufficient certification to support a request for FMLA leave due to a qualifying exigency includes written documentation confirming a covered military member's active duty or call to active duty status in support of a contingency operation. Please check one of the following:

A copy of the covered military member's active duty orders is attached.

Other documentation from the military certifying that the covered military member is on active duty (or has been notified of an impending call to active duty) in support of a contingency operation is attached.

I have previously provided my employer with sufficient written documentation confirming the covered military member's active duty or call to active duty status in support of a contingency operation.

PART A: QUALIFYING REASON FOR LEAVE

1) Describe the reason you are requesting FMLA leave due to a qualifying exigency (including the specific reason you are requesting leave):

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PO Box 110201
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2) A complete and sufficient certification to support a request for FMLA leave due to a qualifying exigency includes any available written documentation which supports the need for leave; such documentation may include a copy of a meeting announcement for informational briefings sponsored by the military, a document confirming an appointment with a counselor or school official, or a copy of a bill for services for the handling of legal or financial affairs. Available written documentation supporting this request for leave is attached. Yes No None Available

PART B: AMOUNT OF LEAVE NEEDED

1) Approximate date exigency commenced: Probable duration of exigency:

2) Will you need to be absent from work for a single continuous period of time due to the qualifying exigency?
Yes No

If so, estimate the beginning and ending dates for the period of absence:

3) Will you need to be absent from work periodically to address this qualifying exigency? Yes No

Estimate schedule of leave, including the dates of any scheduled meetings or appointments:

Estimate the frequency and duration of each appointment, meeting, or leave event, including any travel time (i.e., 1 deployment-related meeting every month lasting 4 hours):
Frequency: _____ times per _____ week(s) _____ month(s)
Duration: _____ hours ___ day(s) per event.

PART C: ADDITIONAL INFORMATION

If leave is requested to meet with a third party (such as to arrange for childcare, to attend counseling, to attend meetings with school or childcare providers, to make financial or legal arrangements, to act as the covered military member's representative before a federal, state, or local agency for purposes of obtaining, arranging or appealing military service benefits, or to attend any event sponsored by the military or military service organizations), a complete and sufficient certification includes the name, address, and appropriate contact information of the individual or entity with whom you are meeting (i.e., either the telephone or fax number or email address of the individual or entity). This information may be used by your employer to verify that the information contained on this form is accurate.

NAME OF INDIVIDUAL: TITLE:

Organization:

Address:

Telephone: Fax: Email:

Describe nature of meeting:

PART D: SIGNATURE

I certify that the information I provided above is true and correct.

Signature of Employee Date