THE STATE of ALASKA

Department of Administration

DIVISION OF PERSONNEL AND LABOR RELATIONS
PAYROLL SERVICES
801 W. 10th Street, Suite B
Juneau, Alaska 99801
OR
550 W. 7th Avenue, Suite 1660
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:
- 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 requires the employee to be absent from the employee's job; or
- 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.
- 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).
- When leave is not foreseeable, the employee must provide notice as soon as reasonably possible.
- 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:
- 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.

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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 for Serious Injury or Illness of Covered Servicemember for Military Family Leave (Family and Medical Leave Act)

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

INSTRUCTIONS to the EMPLOYER:

The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA leave due to a serious injury or illness of a covered servicemember to submit a certification providing sufficient facts to support the request for leave. You may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. § 825.310. This form complies with this requirement and the use of this form is encouraged. Employers must maintain records and documents relating to medical certifications, recertifications, or medical histories of employees or employees' family members, created for FMLA purposes as confidential medical records in separate files/records from the usual personnel files.

SECTION I: For Completion by the EMPLOYEE and/or the COVERED SERVICEMEMBER for whom the Employee Is Requesting Leave

INSTRUCTIONS to the EMPLOYEE or COVERED SERVICEMEMBER:

Please complete Section I before having Section II completed. The FMLA permits an employer to require that an employee submit a timely, complete, and sufficient certification to support a request for FMLA leave due to a serious injury or illness of a covered servicemember. If requested by the employer, your response is required to obtain or retain the benefit of FMLA-protected leave. 29 U.S.C. §§ 2613, 2614(c)(3). Failure to do so may result in a denial of an employee's FMLA request. 29 C.F.R. § 825.310(f). The employer must give an employee at least 15 calendar days to return this form to the employer.

SECTION II: For Completion by a UNITED STATES DEPARTMENT OF DEFENSE ("DOD") HEALTH CARE PROVIDER or a HEALTH CARE PROVIDER who is either: (1) a United States Department of Veterans Affairs ("VA") health care provider; (2) a DOD TRICARE network authorized private health care provider; or (3) a DOD non-network TRICARE authorized private health care provider

INSTRUCTIONS to the HEALTH CARE PROVIDER:

The employee listed on Page 2 has requested leave under the FMLA to care for a family member who is a member of the Regular Armed Forces, the National Guard, or the Reserves who is undergoing medical treatment, recuperation, or therapy, is otherwise in outpatient status, or is otherwise on the temporary disability retired list for a serious injury or illness. For purposes of FMLA leave, a serious injury or illness is one that was incurred in the line of duty on active duty that may render the servicemember medically unfit to perform the duties of his or her office, grade, rank, or rating.

A complete and sufficient certification to support a request for FMLA leave due to a covered servicemember's serious injury or illness includes written documentation confirming that the covered servicemember's injury or illness was incurred in the line of duty on active duty and that the covered servicemember is undergoing treatment for such injury or illness by a health care provider listed above. Answer, fully and completely, all applicable parts. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can; terms such as "lifetime," "unknown," or "indeterminate" may not be sufficient to determine FMLA coverage. Limit your responses to the condition for which the employee is seeking leave.

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***SECTION I*: FOR COMPLETION BY THE EMPLOYEE AND/OR THE COVERED SERVICEMEMBER FOR WHOM THE EMPLOYEE IS REQUESTING LEAVE**. (THIS SECTION MUST BE COMPLETED FIRST BEFORE ANY OF THE BELOW SECTIONS CAN BE COMPLETED BY A HEALTH CARE PROVIDER.)

PART A: EMPLOYEE INFORMATION

Name of Employee Requesting leave to Care for a Covered Servicemember:

Name of Covered Servicemember (for whom employee is requesting leave to care):

Relationship of Employee to Covered Servicemember Requesting Leave to Care:
☐ Spouse ☐ Parent ☐ Son ☐ Daughter ☐ Next of Kin

PART B: COVERED SERVICEMEMBER INFORMATION

1) Is the Covered Servicemember a current member of the Regular Armed Forces, the National Guard or Reserves?
☐ Yes ☐ No
If yes, please provide the Covered Servicemember's military branch, rank, unit currently assigned to:

Is the Covered Servicemember assigned to a military medical treatment facility as an outpatient or to a unit established for the purpose of providing command and control of member of the Armed Forces receiving medical care as outpatients (such as a medical hold or warrior transition unit)? ☐ Yes ☐ No

2) Is Covered Servicemember on the Temporary Disability Retired List (TDRL)? ☐ Yes ☐ No

PART C: CARE TO BE PROVIDED TO THE COVERED SERVICEMEMBER

Describe the care to be provided to the Covered Servicemember and an estimate of the leave needed to provide the care:

***SECTION II*: For Completion by a United States Department of Defense ("DOD") Health Care Provider or a Health Care Provider who is either: (1) a United States Department of Veterans Affairs ("VA") health care provider; (2) a DOD TRICARE network authorized private health care provider; or (3) a DOD non-network TRICARE authorized private health care provider. If you are unable to make certain of the military-related determinations contained below in Part B, you are permitted to rely upon determinations from an authorized DOD representative (such as a DOD recovery care coordinator).**

PART A: HEALTH CARE PROVIDER INFORMATION

Health Care Provider's Name and Business Address:	Type of Practice/Medical Specialty:
Please state whether you are either: (1) a DOD health care provider; (2) a VA health care provider; (3) a DOD TRICARE network authorized private health care provider; or (4) a DOD non-network TRICARE authorized private health care provider:	Telephone: ( ) Fax: ( ) Email:

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PART B: MEDICAL STATUS

1) Covered Servicemember's medical condition is classified as (check one of the appropriate boxes):

☐ **(VSI) Very Seriously Ill/Injured** – Illness/Injury is of such a severity that life is imminently endangered. Family members are requested at bedside immediately. (Please note this is an internal DOD casualty assistance designation used by DOD healthcare providers.)

☐ **(SI) Seriously Ill/Injured** – Illness/injury is of such severity that there is cause for immediate concern, but there is no imminent danger to life. Family members are requested at bedside. (Please note this is an internal DOD casualty assistance designation used by DOD healthcare providers.)

☐ **OTHER Ill/Injured** – A serious injury or illness that may render the Servicemember medically unfit to perform the duties of the member's office, grade, rank, or rating.

☐ **NONE OF THE ABOVE** (Note to Employee: If this box is checked, you may still be eligible to take leave to care for a covered family member with a "serious health condition" under § 825.113 of the FMLA. If such leave is requested, you may be required to complete the Conditional Family Leave Notification form

2) Was the condition for which the Covered Service member is being treated incurred in the line of duty on active duty in the Armed Forces? ☐ Yes ☐ No

3) Approximate date condition commenced:

4) Probable duration of condition and/or need for care:

5) Is the Covered Servicemember undergoing medical treatment, recuperation, or therapy? ☐ Yes ☐ No
If yes, please describe medical treatment, recuperation or therapy:

PART C: COVERED SERVICEMEMBER'S NEED FOR CARE BY FAMILY MEMBER

(1) Will the Covered Servicemember need care for a single continuous period of time, including any time for treatment and recovery? ☐ Yes ☐ No
If yes, estimate the beginning and ending dates for this period of time:

(2) Will the Covered Servicemember require periodic follow-up treatment appointments? ☐ Yes ☐ No
If yes, estimate the treatment schedule:

(3) Is there a medical necessity for the Covered Servicemember to have periodic care for these follow-up treatment appointments? ☐ Yes ☐ No

(4) Is there a medical necessity for the Covered Servicemember to have periodic care for other than scheduled follow-up treatment appointments (e.g., episodic flare-ups of medical condition)? ☐ Yes ☐ No
If yes, please estimate the frequency and duration of the periodic care:

PART D: SIGNATURE

Signature of Health Care Provider:

Printed name of provider:

Date: