THE STATE of ALASKA

DIVISION OF PERSONNEL AND LABOR RELATIONS, ABSENCE MANAGEMENT

Email: soa.absence.management@alaska.gov
Fax: 907-465-1218
Voicemail: 907-269-7951
Mailing: PO Box 110201, Juneau, AK 99811

Certification of Health Care Provider

Section A: Employee/Patient Information		
Employee's Name (Last, First, MI):	Patient's Name:	Relationship of Patient to Employee: Self Parent Spouse Dependent Child (Child's Age)
Employee ID:	Employee's Department:	
List any relative working in same dept and the relationship to employee:		
Signature of Employee:	**Work #:**	**Home #:** **Date:**
Instructions for a 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.		

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:

3. Date condition commenced and probable duration:

4. Date(s) of patient's **present incapacity** (if different from 3):

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): Print name of Health Care Provider:	Address of Health Care Provider: Office Telephone #:
Health Care Provider Signature:	Date Signed:

Return Completed Form to Absence Management

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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]
   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) **One visit 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 therefrom) 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 therefrom.)

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.)

Notice to Medical Provider: The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member, except as specifically allowed by this law. To comply with this law, the State of Alaska, as an employer, asks that you not provide any genetic information when responding to this request for medical information. "Genetic Information" as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

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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 family 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.