State of Alaska

Certification of Health Care Provider

For Employee's Serious Health Condition under the Family and Medical Leave Act

A. Employee Information — TO BE COMPLETED BY EMPLOYEE

Employee Name:_____ **Employee ID**:_____

Department:_____ Division:_____

Work Location:_____ Work Phone:_____

Cell/Preferred Phone:_____ Personal Email:_____

Employee's Job Title:_____ Employee's Regular Schedule:_____

Employee's Essential Job Functions:

Signature of Employee:_____ **Date:**_____

B. Medical Information — TO BE COMPLETED BY HEALTH CARE PROVIDER

Health Care Provider's Name:_____

Type of Practice / Medical Specialty:_____ **License Number:**_____

Health Care Provider's Address:_____

Telephone:_____ **Fax:**_____ **Email:**_____

Select the applicable categories of the employee's SERIOUS HEALTH CONDITION:

☐ **Hospital/Inpatient Care** (e.g., overnight stay in hospital or residential medical care facility)

☐ **Incapacity PLUS Treatment** (e.g., outpatient surgery or short-term illness with incapacity of more than 3 consecutive days with subsequent treatment)

☐ **Pregnancy** **Expected Delivery Date:**_____

☐ **Chronic Condition** (e.g., asthma, migraine headaches, conditions that are episodic and that require medical visits at least twice per year)

☐ **Permanent or Long-Term Condition** (e.g., brain injury, advanced cancer diagnosis, conditions that permanently limit 1 or more major activity of daily living; medical conditions that are considered permanent or long term and that necessitate continual medical supervision)

☐ **Conditions Requiring Multiple Treatments** (e.g., chemotherapy, restorative surgery, non-chronic conditions that require multiple treatments)

PLEASE DESCRIBE THE FACTS OF THE EMPLOYEE'S SERIOUS HEALTH CONDITION:

DATE the condition commenced:_____ Probable DURATION:_____

PLEASE INDICATE THE PRESCRIBED TREATMENT REGIMEN AND SCHEDULE:

- Office visits: #_____ per ☐ day ☐ week ☐ month
- Surgery:_____ Date:_____
- Procedure: _____ Date:_____
- Therapy visits: #_____ ☐ day ☐ week ☐ month
- Are prescription medications part of treatment plan? Yes ☐ or No ☐
- Is the employee currently incapacitated? Yes ☐ or No ☐
- If the employee is currently incapacitated, please estimate duration of incapacitation: _____
- Is the employee currently able to perform the essential functions of the position? Yes ☐ or No ☐
- If not, please describe the employee's work RESTRICTIONS and estimated DURATION of each restriction:

TYPE OF LEAVE REQUESTED:

☐ Continuous Leave:

Leave Start Date:_____ Leave End Date:_____

☐ Intermittent Leave or Reduced Work Schedule:

Episodes of incapacitation are estimated to occur_____ times per ☐day ☐week ☐month

and may last _____☐hours ☐days per episode of incapacity

C. Health Care Provider Signature

Signature of Health Care Provider:_____

Printed Name:_____

Date:_____

Please return completed form to:

Email: soa.absence.management@alaska.gov
Fax Number: 907-465-1218

Mailing Address: PO Box 110201, Juneau, AK 99811

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:
   a. **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*
   b. **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:
   a. 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;
   b. Continues over an **extended period** (including recurring episodes of a significant underlying condition); and
   c. 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).
7) 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.).
8) **Light Duty** is defined as a temporary modification or elimination of one or more of the essential functions of the position (For questions, please contact Employee Relations.).
9)

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.