

## State of Alaska Certification of Health Care Provider For Family Member's Serious Health Condition under the Family and Medical Leave Act

A. Employee Inform	nation		TO BE COMPLETED BY EMPLOYEE	
Employee Name:		Employee	_ Employee ID:	
Department:		Division:		
Work Location:		Work Phor	ne:	
Cell/Preferred Phone:		Personal E	_ Personal Email:	
Name of family men	nber (patient) in need of	care:		
Relationship of fami	ly member incapable of s	self-care to employee:		
☐ Spouse	☐ Parent (includ	les in loco parentis)	☐ Child (includes in loco parentis) - Age	
What type of care w	ill you provide your fami	ly member?		
☐ Assistance with basic medical, hygiene, nutritional, or safety needs ☐ Other:			☐ Other:	
☐ Transportation	☐ Physical Care	☐ Psychological Comfo	ort	
Are you requesting:	☐ Continuous Leave	☐ Intermittent Leave	☐ Both (continuous and intermittent)	
Please provide an es	timate of the amount of	leave being requested:		
Estimated date(s) of	leave needed:			
Signature of Employee:		Da	Date:	
B. Medical Informa	tion	TC	D BE COMPLETED BY HEALTH CARE PROVIDER	
Health Care Provide	r's Name:			
Type of Practice / Medical Specialty:			_License Number:	
Health Care Provide	r's Address:			
Telephone:	Fax:		Email:	
can include assistance	with basic medical care, hyg		the care must be considered medically necessary. This ransportation needs, or psychological comfort. er, they are not required.	

Email Form: <a href="mailto:soa.absence.management@alaska.gov">soa.absence.management@alaska.gov</a>

Fax: 907-465-1218

Select the applicable categories of the patien	t's SERIOUS HEALTH CONDITION:
☐ Hospital/Inpatient Care (e.g., overnight st	ay in hospital or residential medical care facility)
	nt surgery, or short-term illness that requires incapacity of more than 3 ications and/or therapy that requires special equipment)
☐ Pregnancy Expected Delivery Da	te:
☐ Chronic Condition (e.g., asthma, migraine least twice per year)	headaches, conditions that are episodic and that require medical visits at
_	brain injury, advanced cancer diagnosis, conditions that permanently limit edical conditions that are considered permanent or long term and that
☐ Conditions Requiring Multiple Treatments require multiple treatments)	<b>s</b> (e.g., chemotherapy, restorative surgery, non-chronic conditions that
TYPE OF LEAVE NEEDED:	
☐ Continuous Leave: Start Date:	End Date:
☐ Intermittent Leave or Reduced Work Sched	dule:
Please estimate how often the employee	may need intermittent absences or a reduced work schedule:
Employee may need	$\square$ days or $\square$ hours <b>PER</b> $\square$ week or $\square$ month (over the next 6 months)
If appropriate, briefly describe the medical fac	cts that support the request for FMLA:
Date the condition commenced and probable	duration:
Please indicate the prescribed treatment regir	men and schedule:
Office visits: # per □ day □ week □ Surgery (type/date):	☐ month
Health Care Provider Signature	
Signature of Health Care Provider:	
Printed Name:	
Date:	
Please return completed form to:	
Email: Fax Number:	soa.absence.management@alaska.gov 907-465-1218

Email Form: <a href="mailto:soa.absence.management@alaska.gov">soa.absence.management@alaska.gov</a>

Fax: 907-465-1218 DOP AM FORM 555 Rev 230724 v. 1

PO Box 110201, Juneau, AK 99811

Mailing Address:

## 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 <sup>2</sup> 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 <sup>3</sup> 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.q., 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.).

**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 <u>not</u> 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.

Email Form: <a href="mailto:soa.absence.management@alaska.gov">soa.absence.management@alaska.gov</a>

Fax: 907-465-1218

<sup>&</sup>lt;sup>1</sup> Here and elsewhere on this form, the information sought relates only to the condition for which the employee is taking family leave.

<sup>&</sup>lt;sup>2</sup> 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.

<sup>&</sup>lt;sup>3</sup> 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.