



KODIAK ISLAND BOROUGH SCHOOL DISTRICT

**FAMILY AND MEDICAL LEAVE ACT (FMLA)
AND
ALASKA MEDICAL LEAVE ACT (AFLA)
PACKET**

REVISION DATE

1/10/2020



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 service member (qualified family member) recovering from a serious illness or injury sustained in the line of duty while on active duty. A “covered service member” 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.

EMPLOYEE RESPONSIBILITIES:

- When medical certification is required, the employee must **return the completed form to Personnel 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.

Important Links:

- Family Leave Information for State of Alaska Employees-
<http://doa.alaska.gov/dop/serviceCenters/familyLeave/>
<http://doa.alaska.gov/dop/fileadmin/TechnicalServices/pdf/FMLAFAQs.pdf>
<http://www.dol.gov/whd/regs/compliance/posters/fmlaen.pdf>



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

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 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 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.



Office use Only: Actual date leave began: _____ Actual date leave ended: _____
 Actual return date: _____

REQUEST FOR FAMILY/MEDICAL LEAVE

Employee Name: _____ Employee ID _____ Date of request _____
 Position Title _____ Location _____ Hrs per day or FTE _____

I request a Family/Medical Leave for the following reason (check one):

___ A. Pregnancy, the birth of a child and in order to care for such child or the placement of a child with the employee for adoption or foster care. Maximum time available is 18 weeks with restrictions. Doctor's recommendation is required (page 7-8).

___ B. Employee's own serious health condition that requires in patient care or the continuing treatment or supervision by a health care provider, providing the employee is unable to perform the functions of his/her position. Doctor's recommendation required (page 7-8). Maximum of 18 weeks.

___ C. Circle one: SPOUSE-CHILD-PARENT In order to care for an immediate family member if such family member has a serious health condition that requires in-patient care or the continuing treatment or supervision by a health care provider. Doctor's recommendation is required (page 9-10). Maximum of 18 weeks.

(PHYSICIAN MUST COMPLETE CERTIFICATION OF HEALTH CARE PROVIDER FORMS AND RETURN WITHIN 15 DAYS)

Method of leave options (REQUIRED to SELECT ONE):

___ Option (a) Consecutive leave

Date leave is to begin (approximate): _____ **Expected duration:** _____

___ Option (b) Intermittent (or reduced) leave schedule. _____

 Superintendent/Designee Signature Date

In addition to my _____ hours of sick leave, I wish to use _____ hours of annual/personal leave.

Use of leave: Family/Medical leave is unpaid. However, the district substitutes all accrued sick leave prior to any unpaid Family/Medical Leave. Periods of paid leave run concurrently with Family/Medical leave entitlement. Personal and/or annual leave may be used or saved if you wish to take the remaining Family/Medical leave entitlement without pay. Be sure you understand COBRA health benefits in relation to Family/Medical Leave. If the duration of my Family/Medical Leave (total of paid and unpaid time) does not exceed 18 weeks, I will be returned to my same or equivalent position. I understand that if my Family/Medical Leave should exceed 18 weeks, I will be returned to the same or similar position only if available, in accordance with applicable leave laws and contractual agreements.

I understand that if I fail to return from unpaid Family/Medical Leave for reasons other than (1) the continuation, recurrence or onset of a serious health condition of the employee or a covered family member or (2) circumstances beyond the employee's control (certification required within 30 days of failure to return for either reason), KIBSD may seek reimbursement from the employee for the portion of the premiums paid by the District on behalf of that employee during the period of unpaid leave.

 Employee Signature Date

 Building Administrator Signature Date

___ Approved ___ Not Approved

 Superintendent/Designee Signature Date



*Use of leave varies when absence is in conjunction with a work-related injury. Contact Business Department for details.
 Kodiak Island Borough School District, 722 Mill Bay Road, Kodiak, AK 99615 907-486-7551 Fax 907-481-6255
 Kodiak Island Borough School District, 722 Mill Bay Road, Kodiak, AK 99615 907-486-7551 Fax 907-481-6255

Certification of Health Provider

(Family and Medical Leave Act of 1993)
 (Alaska Family Leave Act)

This form is to be completed when family leave is needed for an **EMPLOYEE's** own "serious health condition".

Employee's Name: _____ **SSN:** _____

Release of Medical Information: I authorize the release of any medical information necessary to provide the information requested on this form.

Employee Signature: _____ **Date:** _____

SERIOUS HEALTH CONDITION:

1. The attached sheet describes what is meant by a "serious health condition" under the Family and Medical Leave Act. Does the **employee's condition** qualify under any of the categories described? If so, please check the applicable category.

- _____ (1) Hospital Care
- _____ (2) Absence Plus Treatment
- _____ (3) Pregnancy
- _____ (4) Chronic Conditions Requiring Treatments
- _____ (5) Permanent/Long Term Conditions Requiring Supervision
- _____ (6) Multiple Treatments (Non-Chronic Conditions)
- _____ None of the above

For Serious Health Conditions:

Date condition commenced: _____
 Probable duration of condition: _____

For Pregnancy:

Estimated Due Date: _____
 Estimated Recovery Time: _____

TREATMENTS:

2. Will the employee be absenting from work or other daily activities because of **treatment** on an intermittent or **part-time** basis?

- _____ Yes
- _____ No

If Yes: Number of treatments: _____
 Interval between treatments: _____
 Dates of treatments: _____
 Period of recovery: _____

4. If any of these treatments will be provided by **another provider of health services** (e.g., physical therapist), please state the nature of the treatments:



CERTIFICATION OF HEALTH CARE PROVIDER (Continued)

5. If a **regimen of continuing treatment** by the employee is required under your supervision, provide a general description of such regimen (e.g., prescription drugs, physical therapy requiring special equipment):

INCAPACITY:

*Incapacity, for purposes of FMLA, is defined to mean the inability to work, attend school or perform other regular activities due to the serious health condition, treatment therefor, or recover therefrom.

6. Is the employee **presently incapacitated**?
 _____ Yes
 _____ No
 _____ If yes, give the probable duration: _____
7. If the condition is a **chronic condition** (condition #4) or **pregnancy**, are **episodes of incapacity likely**?
 _____ Yes
 _____ No
 _____ If yes, give the probable frequency of episodes: _____
 _____ If yes, give the probable duration of episodes: _____
8. Will it be necessary for the employee **to work on a reduced schedule** as a result of the condition?
 _____ Yes
 _____ No
 _____ If yes, give the probable duration: _____

ABILITY TO WORK:

9. Is the employee **able to perform** work of any kind?
 _____ Yes
 _____ No
10. If able to perform some work, is the employee **unable to perform any one or more of the essential functions of the employee's job** (the employee or employer should supply you with information about the essential job functions)?
 _____ Yes
 _____ No
 _____ If yes, please list the essential functions the employee is unable to perform:
11. If neither 9 nor 10 applies, is it necessary for the employee to be **absent from work for treatment**?
 _____ Yes
 _____ No

Signature of Health Care Provider

(Type of Practice)

(Date)



Address _____ Telephone Number _____
 Kodiak Island Borough School District, 722 Mill Bay Road, Kodiak, AK 99615 907-486-7551 Fax 907-481-6255

Certification of Health Provider
 (Family and Medical Leave Act of 1993)
 (Alaska Family Leave Act)

This form is to be completed when the employee is needing family leave is needed to CARE FOR A FAMILY MEMBER's "serious health condition".

Employee's Name: _____ Patient's Name: _____

DOB of Patient: _____ Last Four of Social of Patient: _____

Relationship of Patient to Employee: ___ Parent ___ Spouse ___ Dependent Child- Age of Child ___

Release of Medical Information: I authorize the release of any medical information necessary to provide the information requested on this form.

Employee Signature: _____ **Date:** _____

Patient's Signature*: _____ **Date:** _____

*Only if patient is **not** a minor

SERIOUS HEALTH CONDITION:

3. The attached sheet describes what is meant by a "serious health condition" under the Family and Medical Leave Act. Does the **patient's condition** qualify under any of the categories described? If so, please check the applicable category.

- _____ (1) Hospital Care
- _____ (2) Absence Plus Treatment
- _____ (3) Pregnancy
- _____ (4) Chronic Conditions Requiring Treatments
- _____ (5) Permanent/Long Term Conditions Requiring Supervision
- _____ (6) Multiple Treatments (Non-Chronic Conditions)
- _____ None of the above

For Serious Health Conditions:

Date condition commenced: _____

Probable duration of condition: _____

4. Will the employee be absenting from work or other daily activities because of **treatment** on an intermittent or **part-time** basis?

- _____ Yes
- _____ No (full-time basis)

If Yes: Number of treatments: _____

Interval between treatments: _____

Dates of treatments: _____

Period of recovery: _____



Certification of Health Provider (continued)

5. Will the patient require assistance for basic medical, hygiene, nutritional, safety or transportation needs?
_____ Yes
_____ No
6. Is the employee's presence necessary or would it be beneficial for the care of the patient? (This may include psychological comfort.)
_____ Yes
_____ No
7. Estimate the period of time care is needed or the employee's presence would be beneficial for the patient.

Signature of Health Care Provider

(Type of Practice)

(Date)

Address

Telephone Number



ATTENDING PHYSICIAN'S RETURN TO WORK RECOMMENDATIONS

Kodiak Island Borough School District, 722 Mill Bay Road, Kodiak, AK 99615 907-486-7551 Fax 907-481-6218

To be completed by Attending Physician when employee was on leave due to serious health conditions or injury causing incapacity and is returning to work.

Employee Name _____ Appointment Date _____

Next Office Visit Scheduled For _____ Date of Injury _____

I saw and treated this patient on _____ and:

- _____ 1. Recommend patient return to work with no limitations on _____
- _____ 2. Patient is unable to return to work at this time. Patient will be re-evaluated on _____
- _____ 3. Patient may return to work capable of performing the **degree** of work checked below with the following **limitations**:

DEGREE

_____ **Sedentary Work** - Means lifting 10 lbs. maximum and a. Stand/Walk occasionally lifting and/or carrying such articles as files, None 1-4hrs 4-8 hrs 8-12hrs ledgers, small tools, and supplies. Jobs are sedentary if walking and standing are required only occasionally and other sedentary criteria are met. b. Sit None 1-4hrs 4-8 hrs 8-12hrs

_____ **Light Work** - Means lifting 30 lbs. maximum with frequent lifting, and or/ carrying objects weighing up to 20 lbs. Frequent bending, stooping, or squatting may be required. c. Drive No overhead lifting. None 1-4hrs 4-8 hrs 8-12hrs

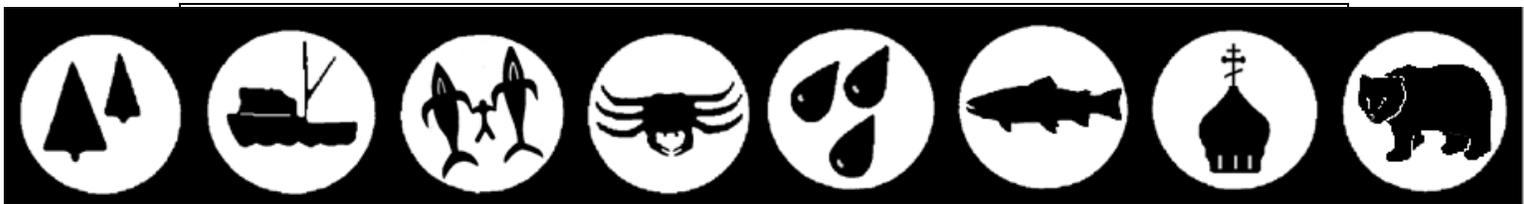
_____ **Medium Work** - Means lifting 50 lbs. maximum with frequent lifting and/or carrying of objects weighing up to 2. Patient may use hands for repetitive: to 35 lbs. Frequent bending, stooping, or squatting may be required. Occasional lifting overhead of no more Power Grip than 20 lbs. Push/Pull Fine Manipulation

_____ **Heavy Work** - Means lifting 75 lbs. maximum & frequent lifting and/or carrying of objects weighing up to 50 lbs. 3. Patient is able to: Frequent bending, stooping, or squatting may be required. Occasional lifting overhead of no more than 30 lbs.

_____ Other limitations and/or restrictions: (attach a separate piece of paper if necessary)

These restrictions are in effect until _____

(continue to next page)



LIMITATIONS

Normal workday for this patient is _____ hours.

(Check those that apply)

A. Stand/Walk

None _____ 1-4 hrs. _____ 4-8 hrs. _____ 8-12 hrs _____

B. Sit

None _____ 1-4 hrs. _____ 4-8 hrs. _____ 8-12 hrs _____

C. Drive

None _____ 1-4 hrs. _____ 4-8 hrs. _____ 8-12 hrs _____

Patient may use hands for repetitive:

| | N/A | Frequently | Occasionally | Not at all |
|-------------------|-------|------------|--------------|------------|
| Power Grip | _____ | _____ | _____ | _____ |
| Push/Pull | _____ | _____ | _____ | _____ |
| Fine Manipulation | _____ | _____ | _____ | _____ |

Patient is able to:

| | N/A | Frequently | Occasionally | Not at all |
|--|-------|------------|--------------|------------|
| Bend | _____ | _____ | _____ | _____ |
| Climb Ladders | _____ | _____ | _____ | _____ |
| Climb Poles | _____ | _____ | _____ | _____ |
| Climb Stairs | _____ | _____ | _____ | _____ |
| Crawl | _____ | _____ | _____ | _____ |
| Crouch | _____ | _____ | _____ | _____ |
| Kneel | _____ | _____ | _____ | _____ |
| Reach overhead | _____ | _____ | _____ | _____ |
| Squat | _____ | _____ | _____ | _____ |
| Walk on rough, Uneven, or frozen Terrain | _____ | _____ | _____ | _____ |

Physician's Signature

Date

Physician's Name (Please print clearly or type)

Name of Clinic

Phone

Fax