LEGISLATIVE AFFAIRS AGENCY
PERSONNEL OFFICE

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Juneau, AK 99801-1182
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FAMILY LEAVE ACT

In 1992 the Alaska State Legislature passed the Alaska Family Leave Act (AFLA) which allows employees to take a leave of absence for a serious illness in the family or for the birth, adoption, or placement, of a child. Then in 1993 Congress passed the federal Family Medical Leave Act of 1993 (FMLA). Unlike most state workers nearly all legislative employees are excluded from coverage under the Federal Act. However, they are subject to Family and Health Leave under AS 39.20.305 and the AFLA. The federal and State Acts are similar, but there are differences. The following information briefly outlines applicability and entitlements under Family and Health Leave and AFLA for Legislative Employees, and explains how to apply for this type of leave.

Applicability

There are two different Alaska statutes that provide for Family and Health Leave. For State employees who normally earn leave AS 39.20.305 (Family and Health Leave) applies. This statute covers the majority of full time and seasonal legislative employees.

Employees that do not earn leave, such as hourly legislative employees, are covered by the AFLA (AS 39.20.500-550). Although there is little difference between the two laws, the Alaska Family Leave Act does require minimum employment thresholds over the previous 6 to 12 months.

Serious Health Condition

An employee who meets the applicability requirements is entitled to take up to 18 weeks of leave during any 24-month period for a serious illness. This may be for an employee's serious illness or to care for a seriously ill spouse, parent, or child of the employee. The 18-week period for illness does not have to be one continuous block of time; it may be broken into different periods over the 24-month period.

Pregnancy or Adoption of a Child

An employee who meets the applicability requirements is entitled to take up to 18 weeks of leave during a 12-month period for pregnancy, birth, adoption, or placement of a child (other than the employee's stepchild). Leave for the birth or adoption of a child must be taken in a single 18-week block. This entitlement expires one year after the birth, adoption, or placement of the child.

Prior Notice

If the use of Family Leave is foreseeable or based on pregnancy, adoption, or planned medical treatment the employee is required to give prior notice to the employer. This notice should be in writing as soon as the need for Family Leave is known. Verbal notice must be followed up in writing.

Additionally, if the reason is for planned medical treatment, the employee must make a reasonable effort to schedule the treatment so as to not unduly disrupt the operations of the agency.

Use of Paid Leave

Family leave is an entitlement rather than a category of paid leave such as 'Personal Leave' or 'Annual Leave'. When taking Family Leave employees who earn Personal Leave are required to use any paid leave accrued until a balance of five days remain in the account. At that point the employee may opt to use the remaining balance or be placed on authorized leave without pay status for the remainder of the Family Leave period. If the employee does not state in writing prior to running out of leave, that they want to retain five days of leave, the Personnel Office will run out all personal leave.

Health Insurance

While in a paid leave status on Family Leave, employees with paid health benefits will continue to receive the same benefit. The employer will continue to pay its portion of the premium each month and the employee will continue to pay their portion (if any) by payroll deduction each pay period.

If the employee is in a leave without pay status, the employer will continue to pay the employer's portion of health premiums through the first twelve weeks Family and Health Leave. In this situation, the employee must pay their portion of the premium (if any) in order to keep health coverage. Premiums paid in this manner must be received by the personnel office no later than the 10th of each month.

When on leave without pay after the first twelve weeks of leave, employees may continue their health insurance by self-paying the full premium.

Return to Work

The law requires an employee be returned to the same or a substantially similar position upon completion of Family Leave. This brings up a situation unique to seasonal or legislative employees. Because legislative staff members are hired for specific periods (session/interim) the Family Leave entitlement of 18 weeks could extend beyond an employment period. In no case will the leave be granted beyond the end of the currently authorized employment period. A supervisor may request a "fit-for-duty" statement from a doctor upon return to duty.

How to Apply for Family Leave

Granting Family Leave is not automatic. You must apply. To apply: notify your supervisor in writing and send a copy of your request to the LAA Personnel Office. The request should include the reason you are asking for Family Leave and the date or approximate date you wish to start. The LAA Personnel Office may send forms for you and your supervisor to complete. These forms provide the details so that a determination can be made on your request.

Once you have completed the forms and your supervisor has approved the leave, the forms are

returned to the LAA Personnel Office. LAA Personnel will contact you to get specific start date information.

To avoid problems or misunderstandings, the most important aspect of applying for Family Leave is communication with your supervisor and the personnel office. Make your request as soon as you know of the need.

Confidentiality Note

Medical information provided when applying for Family Leave is considered confidential. This type of medical information is kept separate from personnel files and destroyed after 9 years.

The above information is only a brief outline of Family and Health Leave. It is not intended to present all of the details. The law gives employees specific rights under certain conditions when needing a leave of absence for serious illness or pregnancy or adoption of a child. If you think you have a need for this type of leave or want more information, you should contact your supervisor and your personnel office for specific details on your situation.

Use of Donated Leave Note:
Employees may use donated leave if they are on family leave. Leave donated must be in four hour increments and must be turned into the Personnel Office prior to the end of the pay period in which it will be used.

Any questions regarding family leave should be directed to the Legislative Affairs Agency, Personnel Office at 465-3854.

Certification of Health Care Provider

(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[1] "** under the FMLA/AFLA. 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.

Date condition commenced:_____
Probable duration of condition:_____

2. Describe the **medical facts** which support your certification, including a brief statement as to how the medical facts meet the criteria of one of these categories:

TREATMENTS:

3. Will the employee be absent 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:

[1] Here and elsewhere on this form, the information sought relates only to the condition for which the employee is taking FMLA/AFLA leave.

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:

6. Is the employee **presently incapacitated**[2] ?

_____ 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 duration of episodes:_____
If yes, give the probable frequency 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 the 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)

[2] **Incapacity**, for purposes of FMLA/AFLA, is defined to mean the inability to work, attend school or perform other regular daily activities due to the serious health condition, treatment therefor, or recovery therefrom.

FMLA/AFLA Information Sheet

For purposes of FMLA/AFLA, **"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] (*i.e.*, 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** 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) **Treatment** by a health care provider on **at least one occasion** which results in a **regimen of continuing treatment**[3] **under the supervision of the health care provider**.

3. **Pregnancy**
Any period of incapacity due to **pregnancy**, or for **prenatal care**.

4. **Chronic Conditions Requiring Treatments**
A **chronic condition** which:
(1) Requires **periodic visits** 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 single 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).

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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 FMLA 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.

Certification of Health Care Provider

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

This form is to be completed when the employee needs family leave to care for a FAMILY MEMBER with a "serious health condition."

Employee's Name:_____ SSN:_____

Patient's Name:_____

Relationship to Employee:_____

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

Patient's Signature:_____ Date:_____

SERIOUS HEALTH CONDITION:

1. The attached sheet describes what is meant by a **"serious health condition[1]"** 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.

   Date condition commenced:_____
   Probable duration of condition:_____

2. Describe the **medical facts** which support your certification, including a brief statement as to how the medical facts meet the criteria of one of these categories:

TREATMENTS:

3. Will the patient be absent 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:

[1] Here and elsewhere on this form the information sought relates only to the patient's condition for which the employee is taking FMLA leave

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

INCAPACITY:

6. Is the patient **presently incapacitated**[2]?

_____ 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 duration of episodes:_____
If yes, give the probable frequency of episodes:_____

CARE PROVIDED:

8. **Does the patient require assistance** for basic medical or personal needs or safety, or for transportation?

_____ Yes
_____ No
If yes, give the probable duration:_____

9. Would the employee's presence to provide **psychological comfort** be beneficial to the patient or assist in the patient's recovery?

_____ Yes
_____ No
If yes, give the probable duration:_____

_____

(Signature of Health Care Provider) (Type of Practice) (Date)

_____

(Address) (Telephone Number)

To be completed by the EMPLOYEE needing family leave to care for a family member:

State the care you will provide and an estimate of the period during which care will be provided. Attach a proposed schedule if leave is to be taken intermittently or if it will be necessary for you to work less than a full schedule.

_____

(Employee Signature) (Date)

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

Family and Medical Leave Act of 1993 Information Sheet

For purposes of FMLA, **"serious health condition"** means an illness, injury, impairment, or physical or mental condition that involves one or more of the following:

1. **Hospital Care**
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(1) **Treatment**[2] **two or more times** 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) **Treatment** by a health care provider on **at least one occasion** which results in a **regimen of continuing treatment**[3] **under the supervision of the health care provider**.

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(2) Continues over an **extended period of time** (including recurring episodes of a single underlying condition); and
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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).

[1] Here and elsewhere on this form, the information sought relates only to the condition for which the employee is taking FMLA 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.