FMLA Packet

Forms Included:

- ✓ Employee Rights, Benefits and Responsibilities While on Leave
- ✓ Employee Rights and Responsibilities under the Family and Medical Leave Act
- ✓ Family and Medical Leave Request/Notification (519-1)
- ✓ Certification of Health Care Provider for Employee's serious health condition (WH-380-E)
- ✓ Health Status Report (519-3)
- ✓ Application for Annual Leave Donations (512-5)
- ✓ Leave without pay Employee Request (512-15)
- ✓ Request for Reasonable Accommodation (519-5)

1. Submit the Family and Medical Leave Request/Notification (Form 519-1) to your OHN.

2. Have your Physician complete and fax the Certification of Health Care Provider for Employee's Serious Health Condition (Form WH-380-E) to the OHN within 15 days of being on medical leave.

3. If you will exhaust your accrued annual and sick leave, submit the Application for Annual Leave Donations (Form 512-5) to your Personnel Liaison if you wish to request annual leave donations from other Department employees. Include a copy of the Health Status Report (Form 519-3). Ensure to include the Diagnosis, Prognosis, and estimated return date.

4. Health Status Report (Form 519-3) will also be used for extensions of FMLA and Donated Annual Leave.

5. Prior to exhausting your time accruals submit the Leave Without Pay Employee Request/Report (Form: 512-15) to the Administrator. Must specify a desired ending date if due to a medical condition, ensure that medical documentation from your physician is included, which identifies the need for your absence, your health limitations, and an anticipated return to work date.

6. Contact the Benefits Unit at (602) 255-2430 to make payment arrangements if on Leave Without Pay. Your benefit coverage will cease unless you make prior arrangements to pay the employee and, in many cases, the employer premiums.

7. If you enrolled in Short-Term Disability during the last Open Enrollment, you may be eligible for short-term disability payments. Visit the Hartford at http://groupbenefits.thehartford.com/arizona/ or by telephone 1-866-712-3443 to file a claim. Policy # GRH-395211

8. If on leave due to disability or medical reasons for more than 6 month (180 consecutive days) you may be eligible for Long-Term Disability Benefits.

    a. **CORP Employees**: Visit the Hartford at http://groupbenefits.thehartford.com/arizona/ or by telephone 1-866-712-3443 to file a claim. Policy # GRH-395211

    b. **ASRS Employees**: Please contact your HR Liaison for Long-Term Disability Packet.

9. If you wish to pursue a possible accommodation through the ADA, you must complete the Request for Reasonable Accommodation Form (519-5); submit recent medical documentation that describes the nature, severity and duration of your disability to your Warden or Administrator. See Department Order 519 for further information or you may contact your Employee Relations Officer.

10. **Prior to returning to work, submit the Health Status Report (Form 519-3) to your OHN to be cleared to return to work.**

11. Employees Helping Employees, Inc. is a non-profit corporation created by employees to provide short term assistance to State employees in crisis. It is not a State Agency. If you would like more information regarding how this organization may be able to help you, please visit the website at http://azehe.org

EMPLOYEE RIGHTS AND RESPONSIBILITIES UNDER THE FAMILY AND MEDICAL LEAVE ACT

Basic Leave Entitlement

FMLA requires covered employers to provide up to 12 weeks of unpaid, job-protected leave to eligible employees for the following reasons:

- for incapacity due to pregnancy, prenatal medical care or child birth;
- to care for the employee's child after birth, or placement for adoption or foster care;
- to care for the employee's spouse, son, daughter or parent, who has a serious health condition; or
- for a serious health condition that makes the employee unable to perform the employee's job.

Military Family Leave Entitlements

Eligible employees whose spouse, son, daughter or parent is on covered active duty or call to covered active duty status may use their 12-week leave entitlement to address certain qualifying exigencies. Qualifying exigencies may include attending certain military events, arranging for alternative childcare, addressing certain financial and legal arrangements, attending certain counseling sessions, and attending post-deployment reintegration briefings.

FMLA also includes a special leave entitlement that permits eligible employees to take up to 26 weeks of leave to care for a covered servicemember during a single 12-month period. A covered servicemember is: (1) a current member of the Armed Forces, including a member of the National Guard or Reserves, who is undergoing medical treatment, recuperation or therapy, is otherwise in outpatient status, or is otherwise on the temporary disability retired list, for a serious injury or illness*; or (2) a veteran who was discharged or released under conditions other than dishonorable at any time during the five-year period prior to the first date the eligible employee takes FMLA leave to care for the covered veteran, and who is undergoing medical treatment, recuperation, or therapy for a serious injury or illness.*

***The FMLA definitions of "serious injury or illness" for current servicemembers and veterans are distinct from the FMLA definition of "serious health condition".**

Benefits and Protections

During FMLA leave, the employer must maintain the employee's health coverage under any "group health plan" on the same terms as if the employee had continued to work. Upon return from FMLA leave, most employees must be restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms.

Use of FMLA leave cannot result in the loss of any employment benefit that accrued prior to the start of an employee's leave.

Eligibility Requirements

Employees are eligible if they have worked for a covered employer for at least 12 months, have 1,250 hours of service in the previous 12 months*, and if at least 50 employees are employed by the employer within 75 miles.

***Special hours of service eligibility requirements apply to airline flight crew employees.**

Definition of Serious Health Condition

A serious health condition is an illness, injury, impairment, or physical or mental condition that involves either an overnight stay in a medical care facility, or continuing treatment by a health care provider for a condition that either prevents the employee from performing the functions of the employee's job, or prevents the qualified family member from participating in school or other daily activities.

Subject to certain conditions, the continuing treatment requirement may be met by a period of incapacity of more than 3 consecutive calendar days combined with at least two visits to a health care provider or one visit and a regimen of continuing treatment, or incapacity due to pregnancy, or incapacity due to a chronic condition. Other conditions may meet the definition of continuing treatment.

Use of Leave

An employee does not need to use this leave entitlement in one block. Leave can be taken intermittently or on a reduced leave schedule when medically necessary. Employees must make reasonable efforts to schedule leave for planned medical treatment so as not to unduly disrupt the employer's operations. Leave due to qualifying exigencies may also be taken on an intermittent basis.

Substitution of Paid Leave for Unpaid Leave

Employees may choose or employers may require use of accrued paid leave while taking FMLA leave. In order to use paid leave for FMLA leave, employees must comply with the employer's normal paid leave policies.

Employee Responsibilities

Employees must provide 30 days advance notice of the need to take FMLA leave when the need is foreseeable. When 30 days notice is not possible, the employee must provide notice as soon as practicable and generally must comply with an employer's normal call-in procedures.

Employees must provide sufficient information for the employer to determine if the leave may qualify for FMLA protection and the anticipated timing and duration of the leave. Sufficient information may include that the employee is unable to perform job functions, the family member is unable to perform daily activities, the need for hospitalization or continuing treatment by a health care provider, or circumstances supporting the need for military family leave. Employees also must inform the employer if the requested leave is for a reason for which FMLA leave was previously taken or certified. Employees also may be required to provide a certification and periodic recertification supporting the need for leave.

Employer Responsibilities

Covered employers must inform employees requesting leave whether they are eligible under FMLA. If they are, the notice must specify any additional information required as well as the employees' rights and responsibilities. If they are not eligible, the employer must provide a reason for the ineligibility.

Covered employers must inform employees if leave will be designated as FMLA-protected and the amount of leave counted against the employee's leave entitlement. If the employer determines that the leave is not FMLA-protected, the employer must notify the employee.

Unlawful Acts by Employers

FMLA makes it unlawful for any employer to:

- interfere with, restrain, or deny the exercise of any right provided under FMLA; and
- discharge or discriminate against any person for opposing any practice made unlawful by FMLA or for involvement in any proceeding under or relating to FMLA.

Enforcement

An employee may file a complaint with the U.S. Department of Labor or may bring a private lawsuit against an employer.

FMLA does 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.

FMLA section 109 (29 U.S.C. § 2619) requires FMLA covered employers to post the text of this notice. Regulation 29 C.F.R. § 825.300(a) may require additional disclosures.

For additional information:
1-866-4US-WAGE (1-866-487-9243) TTY: 1-877-889-5627
WWW.WAGEHOUR.DOL.GOV

U S Department of Labor | Wage and Hour Division

WHD Publication 1420 - Revised February 2013

ARIZONA DEPARTMENT OF CORRECTIONS

Family and Medical Leave Request/Notification

NOTE *– Employee, please read Department Order 519, Employee Health – FMLA, ADA, Industrial Injury, FFD, and Alternate Assignment, section on FMLA prior to completing this form. Also, complete and attach the appropriate Certificate of Healthcare provider (CHCP) listed on Attachment B.*

EMPLOYEE NAME *(Last, First M.I.) (Please print)*	EMPLOYEE IDENTIFICATION NUMBER	INSTITUTION/FACILITY/BUREAU
WORK TELEPHONE NUMBER *(area code)* ( )	DATE *(mm/dd/yyyy)* From:	DATE *(mm/dd/yyyy)* To:

REASON FOR LEAVE

☐ Birth of my child or care for my newborn child or placement of my child for adoption or foster care *(full time leave only).*

☐ To care for my spouse, child or parent with a serious health condition: *(select one below)*

☐ Intermittent ☐ Reduced Work Schedule ☐ Full-Time Leave

☐ A serious health problem which makes me unable to work: *(select one below)*

☐ Intermittent ☐ Reduced Work Schedule ☐ Full-Time Leave

☐ Service Member Leave ☐ Active Duty Leave (*Both Active Duty and Service Member Leave can be taken intermittently or on a reduced Work schedule)

Describe the medical necessity for intermittent or reduced work schedule

Describe when time off or what change in work schedule will be required

I hereby certify that all of the statements contained herein are true to the best of my knowledge. I understand that omissions or misuse of this law may cause rejection of my leave request and/or disciplinary action.

EMPLOYEE'S SIGNATURE	DATE *(mm/dd/yyyy)*
SUPERVISOR'S ACKNOWLEDGMENT	DATE *(mm/dd/yyyy)*

EMPLOYEE – DO NOT WRITE BELOW THIS LINE

Eligibility Verification by the Personnel Liaison

On all requests for FMLA – That the employee has been employed by the state for at least 12 months, worked at least 1250 hours in the last year and the number of hours of FMLA that have been taken in the preceding 12 months from the effective date of this request does not exceed 12 weeks. If ineligible, sign and return to employee. If eligible, sign and forward to OHN for review.

☐ Eligible for _____ weeks in accordance with this request ☐ Ineligible ☐ Insufficient months of work ☐ Insufficient hours of work

☐ FMLA Entitlement exhausted for this 12-month period.

_____ Weeks of FMLA have been taken within twelve months. Will be eligible _____

VERIFY AUTHORITY SIGNATURE	DATE *(mm/dd/yyyy)*

Occupational Health Nurse – I have reviewed medical documentation submitted and find the health condition to be a qualifying event. *(Forward the FMLA Request to the Administrator/Warden as appropriate for signature.)*

☐ Yes ☐ No ☐ CHCP not received

Occupational Health Unit Comments

OCCUPATIONAL HEALTH NURSE SIGNATURE	DATE *(mm/dd/yyyy)*

Final Signature (For further clarification prior to approving this request, you may consult with the Occupational Health Nurse or the Employee Relations Unit.)

DIVISION DIRECTOR/ADMINISTRATOR/WARDEN'S SIGNATURE	REQUEST APPROVED ☐ Yes ☐ No	DATE *(mm/dd/yyyy)*
DATE NOTIFICATION SENT TO EMPLOYEE *(mm/dd/yyyy)*		

Distribution: Original – Supervisor; Copy – Institutional/Central Office Insurance Liaison; Copy – Payroll; Copy – OHU Medical Record

Certification of Health Care Provider for Family Member's Serious Health Condition (Family and Medical Leave Act)

U.S. Department of Labor
Wage and Hour Division

U.S. Wage and Hour Division

DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR; RETURN TO THE PATIENT.

OMB Control Number: 1235-0003
Expires: 5/31/2018

SECTION I: For Completion by the EMPLOYER

INSTRUCTIONS to the EMPLOYER: The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA protections because of a need for leave to care for a covered family member with a serious health condition to submit a medical certification issued by the health care provider of the covered family member. Please complete Section I before giving this form to your employee. Your response is voluntary. While you are not required to use this form, you may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. §§ 825.306-825.308. Employers must generally maintain records and documents relating to medical certifications, recertifications, or medical histories of employees' family members, created for FMLA purposes as confidential medical records in separate files/records from the usual personnel files and in accordance with 29 C.F.R. § 1630.14(c)(1), if the Americans with Disabilities Act applies, and in accordance with 29 C.F.R. § 1635.9, if the Genetic Information Nondiscrimination Act applies.

Employer name and contact: _____

_____

SECTION II: For Completion by the EMPLOYEE

INSTRUCTIONS to the EMPLOYEE: Please complete Section II before giving this form to your family member or his/her medical provider. The FMLA permits an employer to require that you submit a timely, complete, and sufficient medical certification to support a request for FMLA leave to care for a covered family member with a serious health condition. If requested by your employer, your response is required to obtain or retain the benefit of FMLA protections. 29 U.S.C. §§ 2613, 2614(c)(3). Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA request. 29 C.F.R. § 825.313. Your employer must give you at least 15 calendar days to return this form to your employer. 29 C.F.R. § 825.305.

Your name: _____
First Middle Last

Name of family member for whom you will provide care: _____
First Middle Last

Relationship of family member to you: _____

If family member is your son or daughter, date of birth: _____

Describe care you will provide to your family member and estimate leave needed to provide care:

_____

_____

_____

_____ _____
Employee Signature Date

CONTINUED ON NEXT PAGE

SECTION III: For Completion by the HEALTH CARE PROVIDER

INSTRUCTIONS to the HEALTH CARE PROVIDER: The employee listed above has requested leave under the FMLA to care for your patient. Answer, fully and completely, all applicable parts below. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can; terms such as "lifetime," "unknown," or "indeterminate" may not be sufficient to determine FMLA coverage. Limit your responses to the condition for which the patient needs leave. Do not provide information about genetic tests, as defined in 29 C.F.R. § 1635.3(f), or genetic services, as defined in 29 C.F.R. § 1635.3(e). Page 3 provides space for additional information, should you need it. Please be sure to sign the form on the last page.

Provider's name and business address: _____

Type of practice / Medical specialty: _____

Telephone: (_____) _____ Fax: (_____) _____

PART A: MEDICAL FACTS

1. Approximate date condition commenced: _____

   Probable duration of condition: _____

   Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility?
   ___No ___Yes. If so, dates of admission: _____

   Date(s) you treated the patient for condition: _____

   Was medication, other than over-the-counter medication, prescribed? ___No ___Yes.

   Will the patient need to have treatment visits at least twice per year due to the condition? ___No ____ Yes

   Was the patient referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)?
   ____ No ____Yes. If so, state the nature of such treatments and expected duration of treatment:

   _____

   _____

2. Is the medical condition pregnancy? ___No ___Yes. If so, expected delivery date: _____

3. Describe other relevant medical facts, if any, related to the condition for which the patient needs care (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment):

_____

_____

_____

_____

CONTINUED ON NEXT PAGE

PART B: AMOUNT OF CARE NEEDED: When answering these questions, keep in mind that your patient's need for care by the employee seeking leave may include assistance with basic medical, hygienic, nutritional, safety or transportation needs, or the provision of physical or psychological care.

4. Will the patient be incapacitated for a single continuous period of time, including any time for treatment and recovery? ___No ___Yes.

   Estimate the beginning and ending dates for the period of incapacity: _____

   During this time, will the patient need care? __ No __ Yes.

   Explain the care needed by the patient and why such care is medically necessary:

   _____

   _____

   _____

   _____

   _____

5. Will the patient require follow-up treatments, including any time for recovery? ___No ___Yes.

   Estimate treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including any recovery period:

   _____

   Explain the care needed by the patient, and why such care is medically necessary: _____

   _____

6. Will the patient require care on an intermittent or reduced schedule basis, including any time for recovery? __ No __ Yes.

   Estimate the hours the patient needs care on an intermittent basis, if any:

   _____ hour(s) per day; _____ days per week from _____ through _____

   Explain the care needed by the patient, and why such care is medically necessary:

   _____

   _____

   _____

   _____

CONTINUED ON NEXT PAGE

7. Will the condition cause episodic flare-ups periodically preventing the patient from participating in normal daily activities? ____No ____Yes.

Based upon the patient's medical history and your knowledge of the medical condition, estimate the frequency of flare-ups and the duration of related incapacity that the patient may have over the next 6 months (e.g., 1 episode every 3 months lasting 1-2 days):

Frequency: _____ times per _____ week(s) _____ month(s)

Duration: _____ hours or ___ day(s) per episode

Does the patient need care during these flare-ups? ____ No ____ Yes.

Explain the care needed by the patient, and why such care is medically necessary: _____

_____

_____

_____

_____

ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER.

_____

_____

_____

_____

_____

_____

_____ _____

Signature of Health Care Provider **Date**

PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT

If submitted, it is mandatory for employers to retain a copy of this disclosure in their records for three years. 29 U.S.C. § 2616; 29 C.F.R. § 825.500. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. The Department of Labor estimates that it will take an average of 20 minutes for respondents to complete this collection of information, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, U.S. Department of Labor, Room S-3502, 200 Constitution Ave., NW, Washington, DC 20210.
DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR; RETURN TO THE PATIENT.

Certification of Health Care Provider for Employee's Serious Health Condition (Family and Medical Leave Act)

U.S. Department of Labor
Wage and Hour Division

U.S. Wage and Hour Division

DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR; RETURN TO THE PATIENT

OMB Control Number: 1235-0003
Expires: 5/31/2018

SECTION I: For Completion by the EMPLOYER

INSTRUCTIONS to the EMPLOYER: The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA protections because of a need for leave due to a serious health condition to submit a medical certification issued by the employee's health care provider. Please complete Section I before giving this form to your employee. Your response is voluntary. While you are not required to use this form, you may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. §§ 825.306-825.308. Employers must generally maintain records and documents relating to medical certifications, recertifications, or medical histories of employees created for FMLA purposes as confidential medical records in separate files/records from the usual personnel files and in accordance with 29 C.F.R. § 1630.14(c)(1), if the Americans with Disabilities Act applies, and in accordance with 29 C.F.R. § 1635.9, if the Genetic Information Nondiscrimination Act applies.

Employer name and contact: _____

Employee's job title: _____ Regular work schedule: _____

Employee's essential job functions: _____

_____

Check if job description is attached: _____

SECTION II: For Completion by the EMPLOYEE

INSTRUCTIONS to the EMPLOYEE: Please complete Section II before giving this form to your medical provider. The FMLA permits an employer to require that you submit a timely, complete, and sufficient medical certification to support a request for FMLA leave due to your own serious health condition. If requested by your employer, your response is required to obtain or retain the benefit of FMLA protections. 29 U.S.C. §§ 2613, 2614(c)(3). Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA request. 20 C.F.R. § 825.313. Your employer must give you at least 15 calendar days to return this form. 29 C.F.R. § 825.305(b).

Your name: _____
First Middle Last

SECTION III: For Completion by the HEALTH CARE PROVIDER

INSTRUCTIONS to the HEALTH CARE PROVIDER: Your patient has requested leave under the FMLA. Answer, fully and completely, all applicable parts. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can; terms such as "lifetime," "unknown," or "indeterminate" may not be sufficient to determine FMLA coverage. Limit your responses to the condition for which the employee is seeking leave. Do not provide information about genetic tests, as defined in 29 C.F.R. § 1635.3(f), genetic services, as defined in 29 C.F.R. § 1635.3(e), or the manifestation of disease or disorder in the employee's family members, 29 C.F.R. § 1635.3(b). Please be sure to sign the form on the last page.

Provider's name and business address: _____

Type of practice / Medical specialty: _____

Telephone: (_____)_____ Fax:(_____)_____

PART A: MEDICAL FACTS

1. Approximate date condition commenced: _____

   Probable duration of condition: _____

   Mark below as applicable:
   Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility?
   ___No ___Yes. If so, dates of admission:

   _____

   Date(s) you treated the patient for condition:

   _____

   Will the patient need to have treatment visits at least twice per year due to the condition? ___No ___ Yes.

   Was medication, other than over-the-counter medication, prescribed? ___No ___Yes.

   Was the patient referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)?
   ____No ____Yes. If so, state the nature of such treatments and expected duration of treatment:

   _____

2. Is the medical condition pregnancy? ___No ___Yes. If so, expected delivery date: _____

3. Use the information provided by the employer in Section I to answer this question. If the employer fails to provide a list of the employee's essential functions or a job description, answer these questions based upon the employee's own description of his/her job functions.

   Is the employee unable to perform any of his/her job functions due to the condition: ____ No ____ Yes.

   If so, identify the job functions the employee is unable to perform:

   _____

4. Describe other relevant medical facts, if any, related to the condition for which the employee seeks leave (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment):

   _____

   _____

   _____

   _____

   _____

   _____

   _____

CONTINUED ON NEXT PAGE

PART B: AMOUNT OF LEAVE NEEDED

5. Will the employee be incapacitated for a single continuous period of time due to his/her medical condition, including any time for treatment and recovery? ___No ___Yes.

   If so, estimate the beginning and ending dates for the period of incapacity: _____

6. Will the employee need to attend follow-up treatment appointments or work part-time or on a reduced schedule because of the employee's medical condition? ___No ___Yes.

   If so, are the treatments or the reduced number of hours of work medically necessary? ___No ___Yes.

   Estimate treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including any recovery period:

   _____

   Estimate the part-time or reduced work schedule the employee needs, if any:

   _____ hour(s) per day; _____ days per week from _____ through _____

7. Will the condition cause episodic flare-ups periodically preventing the employee from performing his/her job functions? ____No ____Yes.

   Is it medically necessary for the employee to be absent from work during the flare-ups? ____ No ____Yes. If so, explain:

   _____

   _____

   Based upon the patient's medical history and your knowledge of the medical condition, estimate the frequency of flare-ups and the duration of related incapacity that the patient may have over the next 6 months (e.g., 1 episode every 3 months lasting 1-2 days):

Frequency : _____ times per _____ week(s) _____ month(s)

Duration: _____ hours or ___ day(s) per episode

ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER.

_____

_____

_____

_____

_____

_____

CONTINUED ON NEXT PAGE

Signature of Health Care Provider **Date**

PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT

If submitted, it is mandatory for employers to retain a copy of this disclosure in their records for three years. 29 U.S.C. § 2616; 29 C.F.R. § 825.500. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. The Department of Labor estimates that it will take an average of 20 minutes for respondents to complete this collection of information, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, U.S. Department of Labor, Room S-3502, 200 Constitution Ave., NW, Washington, DC 20210. **DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR; RETURN TO THE PATIENT.**

ARIZONA DEPARTMENT OF CORRECTIONS

Health Status Report

HEALTH CARE PROVIDER: ***Please complete this Health Status Report*** *– We may be able to place this employee in a temporary modified duty assignment. Upon receipt of the report and based upon your assessment, we will begin the process of determining the appropriate assignment. This report need only address the issue presented. If you have any questions, please contact:*

Required - Must be completed

EMPLOYEE NAME *(Last, First M.I.) (Please print)*	EMPLOYEE IDENTIFICATION NUMBER	
JOB TITLE	WORK LOCATION	DATE *(mm/dd/yyyy)*
DATE INJURY/ILLNESS BEGAN *(mm/dd/yyyy)*	IS THIS AN INDUSTRIAL INJURY/ILLNESS? ☐ Yes ☐ No	
NATURE OF CONDITION*	**PROGNOSIS***	
ESTIMATED DATE OF RECOVERY *(mm/dd/yyyy)*	DATE OF NEXT APPOINTMENT *(mm/dd/yyyy)*	

WORK STATUS:

- ☐ May work full duty with no restrictions starting on: _____
- ☐ **May work modified light duty starting on** _____ **Approximately how long?*** _____
- ☐ **May work** _____ **hours/day starting on** _____ **Approximately how long?*** _____
- ☐ Off work, starting on _____ Approximately how long? _____
- ☐ Discharged
- ☐ Restrictions are permanent/no improvement expected

EMPLOYEE'S FUNCTIONAL CAPACITY: ***(Check only those that apply)***

- ☐ No lifting, No pushing, No pulling, No running
- ☐ No lifting over _____ pounds
- ☐ No repetitive bending/twisting
  Body Part _____
- ☐ No repetitive motion to injured part *(i.e., leg, arm)* _____
- ☐ No climbing _____ ladders _____ stairs _____
- ☐ Able to traverse _____ stairs to enter a room or building
- ☐ No inmate control/intervention activities
- ☐ No operation of a motor vehicle
- ☐ No operation of hazardous equipment
- ☐ No work reaching above the shoulder

- ☐ Workday Capacity
  Can sit _____ hours/day
  Can stand _____ hours/day
  Can walk _____ hours/day
- ☐ Visual Limitations *(What is the limitation)*
- ☐ Psychological Limitations *(What is the limitation)*
- ☐ Environmental Limitations *(What is the limitation)*

COMMENTS

PROVIDER NAME *(Last, First M.I.) (Please print)*	ADDRESS *(Street no., city, state, zip code)*	TELEPHONE NUMBER *(area code)*
SIGNATURE		DATE *(mm/dd/yyyy)*

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 of the individual, except as specifically allowed by this law. To comply with this law, we are asking 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.

ARIZONA DEPARTMENT OF CORRECTIONS

Agreement to Receive Annual Leave Contributions

Donation of Annual Leave is defined in the Arizona Department of Administration Personnel Rules, R2-5A-B602 and Department Order 512, Employee Pay, Work Hours, Compensation and Leave.

NAME OF INJURED/ILL EMPLOYEE OR QUALIFYING FAMILY MEMBER *(Last, First M.I.) (Please print)*		
IF YOU ARE REQUESTING DAL FOR A QUALIFYING FAMILY MEMBER, PLEASE PRINT YOUR FULL NAME		
EMPLOYEE IDENTIFICATION NUMBER	MAILING ADDRESS *(Street no., P.O. box, city, state, zip code)*	
EMAIL ADDRESS	HOME TELEPHONE NUMBER *(area code)* ( )	
DIVISION/BUREAU/UNIT	WORK UNIT PHONE NUMBER *(area code)* ( )	JOB TITLE
HEALTH CARE PRACTITIONER'S NAME *(Last, First M.I.) (Please print)*	HEALTH CARE PRACTITIONER'S TELEPHONE NUMBER *(area code)* ( )	
HEALTH CARE PRACTITIONER'S ADDRESS *(City, state, zip code.)*		

Read and initial each statement below:

_____ I understand it is my responsibility to provide a copy of my Health Care Practitioner's diagnosis, prognosis, and anticipated date of return to my Human Resources Liaison. All information I provide will be kept confidential and shared only with those who need to know.

_____ Should I remain off work past the approved expiration date, I understand it will be my responsibility to provide an updated diagnosis, prognosis, and an anticipated date of return statement from my Health Care Practitioner 10 days prior to the initially approved expiration date.

_____ I understand I must exhaust all of my sick and annual leave prior to the use of any leave donations.

_____ I understand in order to qualify, the illness/injury must be for duration of at least 3 consecutive weeks to a maximum of 6 consecutive months.

_____ If this request is for an immediate family member, I must have taken 40-hours of sick leave, if applicable, for this situation during this calendar year, and exhausted all annual leave.

_____ I understand the donated annual leave will not be applied retroactively.

_____ I understand that I am responsible for making personal payment for my benefits for any period that I am on a leave without pay *(LWOP)* status.

_____ I understand I am eligible for Donated Annual Leave *(DAL)* for 6 months. This period may only be extended briefly to allow a determination to be made for Long Term Disability *(LTD)* benefits, if I have applied for Long term Disability benefits by the end of the 5th month of leave. I further understand, my LTD payment may be reduced by any leave donations I receive after my LTD approval date.

_____ I understand that it is in my best interest to apply for Long Term Disability at the end of the 3rd month of my absence, if the prognosis of my illness or injury is expected to be longer than 6 months.

_____ I understand that if I am awarded Long Term Disability benefits, I will no longer be eligible to receive donated annual leave donations and any all unused donated annual leave donations on my leave balances at the time of my LTD approval will be returned to the appropriate contributors.

_____ I understand that if I returned to work prior to the approved end date of my donated annual leave, all unused donated annual leave will be returned to the appropriate contributors.

By signing below, I understand and agree with the eligibility requirements of the donated annual leave program.

EMPLOYEE NAME *(Last, First M.I.) (Please print)*	SIGNATURE	DATE *(mm/dd/yyyy)*

If the employee is unable to sign this form, the employee's supervisor, spouse or parent may sign on the employee's behalf. A copy of this form will be mailed directly to the employee by the Human Resources Liaison or by the Human Resources Operations Unit.

RELATIONSHIP TO EMPLOYEE	SIGNATURE	DATE *(mm/dd/yyyy)*

Agreement to Receive Annual Leave Contributions – Continuation

EMPLOYEE NAME *(Last, First M.I.) (Please print)*	EMPLOYEE IDENTIFICATION NUMBER
WORK LOCATION	

HUMAN RESOURCES USE ONLY *(Check upon completion)*

- ☐ Explained the DAL extension process to the employee
- ☐ Explained the LTD process and when to file to the employee
- ☐ Copy of the Health Care Practitioner's prognosis/diagnosis/anticipated date of return. *(Attached)*
- ☐ Explained LWOP to the employee and its impact on the employee group insurance.
- ☐ Verified all paperwork was completed and the required documentation met the DAL criteria.
- ☐ Advised employee of the DAL procedure, time frames and mandatory documentation.

Last Day Worked _____ As of _____ Annual _____ Comp _____

Sick/Sick Family _____ Holiday _____

Date submitted to the Human Resources Operations: _____ *(mm/dd/yyyy)*

HUMAN RESOURCES STAFF NAME *(Last, First M.I.) (Please print)*	SIGNATURE	DATE *(mm/dd/yyyy)*
HUMAN RESOURCES LIAISON NAME *(Last, First M.I.) (Please) print)*	SIGNATURE	DATE *(mm/dd/yyyy)*

HUMAN RESOURCES OPERATIONS USE ONLY

☐ Approved through: _____ Illness/Injury is seriously incapacitating and extended pursuant to the ADOA Personnel Rule, R2-5A-B602. Approval indicates the request and documentation meet policy requirements. Leave balance status will be monitored by the ADC Payroll.

☐ Disapproval - Illness/injury is not seriously incapacitating and does not meet the qualifying criteria as defined in the ADOA Personnel Rule.

☐ Disapproval - Prognosis/Diagnosis is incomplete or not provided.

☐ Disapproval - Other _____

AUTHORIZED SIGNATURE	DATE *(mm/dd/yyyy)*

☐ Extension # 1: Approved through: _____ *(mm/dd/yyyy)* _____ Authorized Signature / Date *(mm/dd/yyyy)*

☐ Extension # 2: Approved through: _____ *(mm/dd/yyyy)* _____ Authorized Signature / Date *(mm/dd/yyyy)*

☐ Extension # 3: Approved through: _____ *(mm/dd/yyyy)* _____ Authorized Signature / Date *(mm/dd/yyyy)*

☐ Extension # 4: Approved through: _____ *(mm/dd/yyyy)* _____ Authorized Signature / Date *(mm/dd/yyyy)*

CENTRAL OFFICE PAYROLL USE ONLY

Last Day Worked _____ Hourly Rate _____

Pay Period in Which Leave was Exhausted _____ Department Levels _____

Authorized Payroll Liaison Signature _____ Date *(mm/dd/yyyy)* _____

Distribution: Original – DAL File
Copy – Human Resources Liaison
Copy – Central Office Payroll *(Approvals only)*

512-5(e)
7/16/15

ARIZONA DEPARTMENT OF CORRECTIONS

Request for Reasonable Accommodation

EMPLOYEE NAME *(Last, First M.I.) (Please print)*	JOB CLASS TITLE	CLASS CODE
POSITION NUMBER	WORK LOCATION/UNIT	HOME TELEPHONE NUMBER *(area code)*

Describe the requested accommodation. *(DO NOT include information about the nature of the disability)*

I am requesting accommodation for a disability as defined by the Americans with Disabilities Act. I have a physical or mental impairment that substantially limits one or more major life activities.

EMPLOYEE SIGNATURE	DATE *(mm/dd/yyyy)*

I have discussed the essential functions of the position with the employee and have identified that a reasonable accommodation may be required so that the employee can perform one or more of those functions. I have discussed the possibility of providing an accommodation with the candidate/employee and have the following recommendations:

WARDEN OR ADMINISTRATOR NAME *(Last, First M.I.) (Please print)*

SIGNATURE	DATE *(mm/dd/yyyy)*

The following accommodation has been requested and not approved:

The following reasonable accommodation was requested and is approved:

The reason(s) for not approving this accommodation are:

HUMAN SERVICES BUREAU ADMINISTRATOR NAME *(Last, First M.I.) (Please print)*

SIGNATURE	DATE *(mm/dd/yyyy)*

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 of the individual, except as specifically allowed by this law. To comply with this law, we are asking 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.

ARIZONA DEPARTMENT OF CORRECTIONS

Leave Without Pay Employee Request/Report
R2-5-414

PLEASE NOTE: Employee on approved Industrial Leave pay only their share of costs for the first six months. After six months, they pick up entire premium rate.

TO: _____ *(Supervisor name) (Last, First M.I.) (Please print)*	FACILITY/LOCATION/UNIT
FROM: _____ *(Employee name) (Last, First M.I.) (Please print)*	SOCIAL SECURITY NUMBER

TYPE OF LEAVE

☐ Industrial ☐ Maternity ☐ Personal ☐ Medical ☐ Educational

REASON FOR LEAVE:

EMPLOYEE SIGNATURE	DATE *(mm/dd/yyyy)*
APPROVING AUTHORITY SIGNATURE ☐ Approved ☐ Disapproved	DATE *(mm/dd/yyyy)*

ACCRUAL BALANCES:
(at time of request)

ANNUAL LEAVE	SICK LEAVE	COMP-TIME
LAST DAY WORKED *(mm/dd/yyyy)*	LAST DATE ACCRUALS USED *(mm/dd/yyyy)*	
EFFECTIVE LEAVE WITHOUT PAY DATE *(mm/dd/yyyy)*	APPROXIMATE RETURN DATE *(mm/dd/yyyy)*	

Employee Insurance Coverage End Date: _____ / _____ / _____

Prepared By: _____ _____
(Insurance Liaison Signature) Date *(mm/dd/yyyy)*

COMMENTS

ARIZONA DEPARTMENT OF CORRECTIONS

Occupational Health Unit - Report of Prescription Medications

EMPLOYEE NAME *(Last, First M.I.) (Please print)*	EMPLOYEE IDENTIFICATION NUMBER

Dear Healthcare Provider:

The above named employee has reported to the Arizona Department of Corrections' Occupational Health Nurse (OHN) that he/she is taking medication(s) that may have been prescribed by you. In order to determine whether any medication(s), or a combination thereof, may cause side effects which may limit the employee's ability to be continuously alert, closely observant, and reliably responsive under potentially dangerous circumstances that are typical of a safety-sensitive position in a prison environment. The Department requests that you please indicate below the name, dosage and frequency for each medication the employee is prescribed.

Name of Medication	Dosage	Frequency Used

I certify that I have prescribed the medication(s) as listed above.

HEALTH CARE PROVIDER NAME *(Last, First M.I.) (Please print)*	
SIGNATURE	DATE *(mm/dd/yyyy)*

Please return completed form to the employee or fax to the Unit Occupational Health Nurse (OHN).

OHN NAME *(Last, First M.I.) (Please print)*	TELEPHONE NUMBER *(area code)*	FAX NUMBER *(area code)*