Arizona Department of Corrections Rehabilitation and Reentry

Family and Medical Leave Request/Notification

NOTE **–** *Employee, please read Department Order 519, Employee Health – State/Federal Programs and Assignments, 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 PRINTED NAME *(Last, First M.I.)*	EIN	JOB TITLE

SHIFT	INSTITUTION/FACILITY/BUREAU/UNIT	CONTACT TELEPHONE NUMBER *(area code)*

BEGIN DATE *(mm/dd/yyyy)*	END DATE *(mm/dd/yyyy)*	DATE FMLA PACKET PROVIDED *(mm/dd/yyyy)*

REASON FOR LEAVE

- ☐ Birth of my child or placement of my child for adoption or foster care
- ☐ A serious health condition which makes me unable to work
- ☐ To care for my spouse, child or parent with a serious health condition *(select one below)*
- ☐ A serious injury or illness of a Covered Service member or Veteran *(may qualify for up to 26 weeks of leave)*
- ☐ Qualifying Exigency for Military Family Leave

Have you worked at any State agency as a contractor or through a staffing company during the last 7 years? ☐ Yes ☐ No If yes, please specify the State agency you worked and the dates you worked at the agency.

TYPE OF LEAVE: ☐ Full-time Leave ☐ Intermittent Leave ☐ Reduced Work Schedule

LEAVE IS TO CARE FOR: ☐ Self ☐ Spouse ☐ Child ☐ Parent ☐ Military Caregiver

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 SIGNATURE	DATE *(mm/dd/yyyy)*

EMPLOYEE – DO NOT WRITE BELOW THIS LINE

FMLA ELIGIBLE

Hire Date _____ Employed by the state for at least 12 months? ☐ Yes If No → ☐ Ineligible – Insufficient months of work

Number of hours worked _____ Meets the 1,250 hour criteria? ☐ Yes If No → ☐ Ineligible – Insufficient hours worked

Previous FMLA hours used? ☐ Yes ☐ No If yes, number of hours _____ ☐ FMLA entitlement exhausted for this 12 month Period

Eligible for: Weeks _____ Hours _____ HRIS XT51 Record _____

HR STAFF / DATE *(mm/dd/yyyy)*	AUDITED BY / DATE *(mm/dd/yyyy)*	IF INELIGIBLE, SECOND AUDIT BY / DATE *(mm/dd/yyyy)*

Upon completion of HR Liaison section, if eligible for FMLA forward to the OHN. If Ineligible for FMLA, forward to the appropriate EA, ESA or FMLA Coordinator for final notification and copy OHN.

HUMAN RESOURCES STAFF SIGNATURE	DATE *(mm/dd/yyyy)*

OCCUPATIONAL HEALTH NURSE – I have reviewed the request for FMLA and have found the following:

Date CHCP form Received: _____ ☐ CHCP not received, FMLA denied

☐ I hereby find the health condition to be a qualifying event. ☐ I hereby find the health condition to be a non-qualifying event.

WORK RELATED INJURY/ILLNESS ☐ Yes ☐ No If yes, Risk Management Case Number: _____

OCCUPATIONAL HEALTH UNIT COMMENTS

OHN 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.)*

ASSISTANT DIRECTOR/ADMINISTRATOR/WARDEN SIGNATURE:

FMLA LEAVE STATUS: ☐ Approved ☐ Closed ☐ Denied ☐ Ineligible

(HR STAFF) KEYED BY:	**DATE:** *(mm/dd/yyyy)*

Distribution: ***Original*** – Occupational Health Unit, ***Copy*** – Institutional/Central Office Human Resources Liaison; Payroll; ER; Timekeeper; Supervisor

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

U.S. Department of Labor
Wage and Hour Division

WAGE AND HOUR DIVISION

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

OMB Control Number: 1235-0003
Expires: 6/30/2026

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. 29 U.S.C. §§ 2613, 2614(c)(3); 29 C.F.R. § 825.305. The employer must give the employee at least 15 calendar days to provide the certification. If the employee fails to provide complete and sufficient medical certification, his or her FMLA leave request may be denied. 29 C.F.R. § 825.313. Information about the FMLA may be found on the WHD website at www.dol.gov/agencies/whd/fmla.

SECTION I - EMPLOYER

Either the employee or the employer may complete Section I. While use of this form is optional, this form asks the health care provider for the information necessary for a complete and sufficient medical certification, which is set out at 29 C.F.R. § 825.306. **You may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. §§ 825.306-825.308.** Additionally, you **may not** request a certification for FMLA leave to bond with a healthy newborn child or a child placed for adoption or foster care.

Employers must generally maintain records and documents relating to medical information, 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.

(1) Employee name: _____
First Middle Last

(2) Employer name: _____ Date: _____ (mm/dd/yyyy)
(List date certification requested)

(3) The medical certification must be returned by _____ (mm/dd/yyyy)
(Must allow at least 15 calendar days from the date requested, unless it is not feasible despite the employee's diligent, good faith efforts.)

(4) Employee's job title: _____ Job description ☐ is / ☐ is not attached.

Employee's regular work schedule: _____

Statement of the employee's essential job functions:

_____

(The essential functions of the employee's position are determined with reference to the position the employee held at the time the employee notified the employer of the need for leave or the leave started, whichever is earlier.)

SECTION II - HEALTH CARE PROVIDER

Please provide your contact information, complete all relevant parts of this Section, and sign the form. Your patient has requested leave under the FMLA. The FMLA allows an employer to require that the employee submit a timely, complete, and sufficient medical certification to support a request for FMLA leave due to the serious health condition of the employee. For FMLA purposes, a "serious health condition" means an illness, injury, impairment, or physical or mental condition that involves **inpatient care** or **continuing treatment by a health care provider**. For more information about the definitions of a serious health condition under the FMLA, see the chart on page 4.

You also may, but are **not required** to, provide other appropriate medical facts including symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment. Please note that some state or local laws may not allow disclosure of private medical information about the patient's serious health condition, such as providing the diagnosis and/or course of treatment.

Employee Name: _____

Health Care Provider's name: (Print) _____

Health Care Provider's business address: _____

Type of practice / Medical specialty: _____

Telephone: _____ Fax: _____ E-mail: _____

PART A: Medical Information

Limit your response to the medical condition(s) for which the employee is seeking FMLA leave. Your answers should be your **best estimate** based upon your medical knowledge, experience, and examination of the patient. **After completing Part A, complete Part B to provide information about the amount of leave needed.** Note: For FMLA purposes, "incapacity" means the inability to work, attend school, or perform regular daily activities due to the condition, treatment of the condition, or recovery from the condition. 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).

(1) State the approximate date the condition started or will start: _____ (mm/dd/yyyy)

(2) Provide your **best estimate** of how long the condition lasted or will last: _____

(3) Check the box(es) for the questions below, as applicable. For all box(es) checked, the amount of leave needed must be provided in Part B.

☐ **Inpatient Care**: The patient (☐ has been / ☐ is expected to be) admitted for an overnight stay in a hospital, hospice, or residential medical care facility on the following date(s): _____

☐ **Incapacity plus Treatment**: (e.g. outpatient surgery, strep throat)

Due to the condition, the patient (☐ has been / ☐ is expected to be) incapacitated for **more than** three consecutive, full calendar days from: _____ (mm/dd/yyyy) to _____ (mm/dd/yyyy).

The patient (☐ was / ☐ will be) seen on the following date(s): _____

_____

The condition (☐ has / ☐ has not) also resulted in a course of continuing treatment under the supervision of a health care provider (e.g. prescription medication (other than over-the-counter) or therapy requiring special equipment).

☐ **Pregnancy**: The condition is pregnancy. List the expected delivery date: _____ (mm/dd/yyyy).

☐ **Chronic Conditions**: (e.g. asthma, migraine headaches) Due to the condition, it is medically necessary for the patient to have treatment visits at least twice per year.

☐ **Permanent or Long Term Conditions**: (e.g. Alzheimer's, terminal stages of cancer) Due to the condition, incapacity is permanent or long term and requires the continuing supervision of a health care provider (even if active treatment is not being provided).

☐ **Conditions requiring Multiple Treatments**: (e.g. chemotherapy treatments, restorative surgery) Due to the condition, it is medically necessary for the patient to receive multiple treatments.

☐ **None of the above**: If none of the above condition(s) were checked, (i.e., inpatient care, pregnancy) no additional information is needed. Go to page 4 to sign and date the form.

Employee Name: _____

(4) If needed, briefly describe other appropriate medical facts related to the condition(s) for which the employee seeks FMLA leave. (e.g., use of nebulizer, dialysis)

_____

PART B: Amount of Leave Needed

For the medical condition(s) checked in Part A, complete all that apply. 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.

(5) Due to the condition, the patient (☐ had / ☐ will have) **planned medical treatment(s)** (scheduled medical visits) (e.g.psychotherapy, prenatal appointments) on the following date(s): _____

_____

(6) Due to the condition, the patient (☐ was / ☐ will be) **referred to other health care provider(s)** for evaluation or treatment(s).

State the nature of such treatments: (e.g. cardiologist, physical therapy) _____

Provide your **best estimate** of the beginning date _____ (mm/dd/yyyy) and end date _____ (mm/dd/yyyy). for the treatment(s).

Provide your **best estimate** of the duration of the treatment(s), including any period(s) of recovery (e.g. 3 days/week)

_____

(7) Due to the condition, it is medically necessary for the employee to work a **reduced schedule**.

Provide your **best estimate** of the reduced schedule the employee is able to work. From _____ (mm/dd/yyyy) to _____ (mm/dd/yyyy) the employee is able to work: (e.g., 5 hours/day, up to 25 hours a week)

_____

(8) Due to the condition, the patient (☐ was / ☐ will be) **incapacitated for a continuous period of time**, including any time for treatment(s) and/or recovery.

Provide your **best estimate** of the beginning date _____ (mm/dd/yyyy) and end date _____ (mm/dd/yyyy). for the period of incapacity.

(9) Due to the condition, it (☐ was / ☐ is / ☐ will be) medically necessary for the employee to be absent from work on an intermittent basis (periodically), including for any episodes of incapacity i.e., episodic flare-ups. Provide your **best estimate** of how often (frequency) and how long (duration) the episodes of incapacity will likely last.

Over the next 6 months, episodes of incapacity are estimated to occur _____ times per (☐ day ☐ week ☐ month) and are likely to last approximately _____ (☐ hours ☐ days) per episode.

Employee Name: _____

PART C: Essential Job Functions

If provided, the information in Section I question #4 may be used to answer this question. If the employer fails to provide a statement of the employee's essential functions or a job description, answer these questions based upon the employee's own description of the essential job functions. An employee who must be absent from work to receive medical treatment(s), such as scheduled medical visits, for a serious health condition is considered to be **not able** to perform the essential job functions of the position during the absence for treatment(s).

(10) Due to the condition, the employee (☐ was not able / ☐ is not able / ☐ will not be able) to perform **one or more** of the essential job function(s). Identify at least one essential job function the employee is not able to perform:

_____

Signature of Health Care Provider _____ Date: _____ (mm/dd/yyyy)

Definitions of a Serious Health Condition (See 29 C.F.R. §§ 825.113-.115)
Inpatient Care
• An overnight stay in a hospital, hospice, or residential medical care facility. • Inpatient care includes any period of incapacity or any subsequent treatment in connection with the overnight stay.
Continuing Treatment by a Health Care Provider (any one or more of the following)
Incapacity Plus Treatment: A period of incapacity of more than three consecutive, full calendar days, and any subsequent treatment or period of incapacity relating to the same condition, that also involves either: o Two or more in-person visits to a health care provider for treatment within 30 days of the first day of incapacity unless extenuating circumstances exist. The first visit must be within seven days of the first day of incapacity; or, o At least one in-person visit to a health care provider for treatment within seven days of the first day of incapacity, which results in a regimen of continuing treatment under the supervision of the health care provider. For example, the health provider might prescribe a course of prescription medication or therapy requiring special equipment.
Pregnancy: Any period of incapacity due to pregnancy or for prenatal care. _____
Chronic Conditions: Any period of incapacity due to or treatment for a chronic serious health condition, such as diabetes, asthma, migraine headaches. A chronic serious health condition is one which requires visits to a health care provider (or nurse supervised by the provider) at least twice a year and recurs over an extended period of time. A chronic condition may cause episodic rather than a continuing period of incapacity.
Permanent or Long-term Conditions: A period of incapacity which is permanent or long-term due to a condition for which treatment may not be effective, but which requires the continuing supervision of a health care provider, such as Alzheimer's disease or the terminal stages of cancer.
Conditions Requiring Multiple Treatments: Restorative surgery after an accident or other injury; or, a condition that would likely result in a period of incapacity of more than three consecutive, full calendar days if the patient did not receive the treatment.

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 15 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 Avenue, N.W., Washington, D.C. 20210.

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

Arizona Department of Corrections Rehabilitation and Reentry

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, and must be submitted to the Occupational Health Nurse (OHN). If you have any questions, please contact:*

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** _____ **Approximately how long?*** _____

☐ **May work** _____ **hours/day starting on** _____ **Approximately how long?*** _____

☐ Off work, starting _____ Approximately how long? _____

☐ Discharged from care ☐ No permanent impairment

☐ Restrictions are permanent/no improvement expected

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

☐ 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)*

This completed form must be provided to the OHN:

OHN's Fax Number *(area code)* _____ OHN's Telephone Number *(area code)* _____

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 REHABILITATION AND REENTRY

EMPLOYEE RIGHTS, BENEFITS, and RESPONSIBILITIES WHILE ON LEAVE – QUICK GUIDE

This handout contains basic information only and is intended to be a guide and quick reference tool for you as an employee of the Department of Corrections Rehabilitation and Reentry. It provides information concerning your rights, benefits and responsibilities in the event you are off work due to your inability to perform your regularly assigned duties for health related reasons or in the event you need to care for an immediate family member. You are encouraged to keep apprised of changes and to consult your supervisor, the Occupational Health Unit and/or Complex/Bureau Human Resources Liaison.

Family and Medical Leave Act (FMLA)

The Family and Medical Leave Act of 1993 allows eligible employees to be absent with a job guarantee upon return to work and with continued benefit coverage for a period of 12 weeks within a 12-month period. This is unpaid leave unless you have accrued leave to cover your absence. To be eligible; you must have worked for the State of Arizona for at least 12 months; worked at least 1250 hours within the last 12 months and be absent due to the birth of a child, the placement for adoption of a child or for your serious medical condition or the serious medical condition of an immediate family member. If eligible, you can or you will be placed on FMLA. You must complete an FMLA Request/Notification, form 519-1, and a Request for Leave, form 512-3 and submit them to your immediate supervisor. If the FMLA is for your serious medical condition you must also submit a Certification of Health Care Provider (CHCP), form WH-380 (E or F) to the Occupational Health Nurse no later than 15 (calendar) days from the date of request. Failure to provide the CHCP may result in delay or denial. If clarification or follow-up is needed to rectify any deficiencies in regards to the CHCP, you will receive an additional 7 (calendar) days. Once the documentation is received, you will be notified of your FMLA leave status.

Until you are notified of your status, you should not assume you are on approved FMLA leave. You are expected to follow call-in procedures as outlined in Department Order 525. If you have questions about your status or call-in procedures, please contact your supervisor.

Paid Parental Leave (PPL)

An eligible employee for the purposes of the Paid Parental Leave Pilot Program is an employee who, on or after **January 1, 2023**, and upon the birth or new placement of a child, is an employee of the state of Arizona and at the commencement of taking paid Parental Leave:

- Has been employed by the state of Arizona for at least 12 months during the past 7 years; and
- Has worked a minimum of 1250 hours during the past year (paid leave does not count towards this requirement, only hours worked)

- An agency head shall not extend paid leave under this Pilot Program to an ineligible employee (i.e. Temporary Employees, Employees not meeting the required hours, etc.).

**Leave amounts are based on full-time employment and shall be pro-rated for part-time employees.*

Eligibility will be determined by Human Resources and should not be determined at the Supervisor/Manager level.

- **Upon the birth or new placement of a child, form (ASPS/FA6.07) should be submitted to the assigned OHN office along with supporting documentation, i.e, Birth Certificate, Crib Card, or CHCP/Doctor's Certification or documentation from an adoption or foster care agency regarding the placement.** Once the OHN verifies, it will then be sent out for final verification from HR and approval through the assigned Warden or Administrator. The employee will then be sent a signed copy of the form noting the approval status.

Industrial Injury/Illness

If you are eligible for Worker's Compensation due to sustaining an injury, illness or disease arising out of and in the course of employment contact information is as follows:
1-800-685-2877

This is a 24 hour 7 day a week Nurse Triage line service contracted by ADOA-Risk Management/Workers' Compensation Division. When you call this number to report a work related injury/illness, you will speak with a Registered Nurse who will advise if you need to go to a hospital or clinic and follow up with your OHN.

Health Insurance Coverage

When on leave without pay, your benefit coverage will cease unless you pay the employee and, in many cases, the employer premiums. Contact the Arizona Department of Administration at 602-542-5008 or ADCRR Benefits at benefits@azadc.gov for questions or concerns. Keeping premium payments timely will ensure confirmed coverage.

Short-Term Disability

Policy Holder: State of Arizona

What is it? Short-Term Disability (STD) is insurance that pays you a portion of your earnings if you are sick or hurt and cannot work. STD will help to make up for lost income. Short-Term Disability will benefit pay up to 66-2/3% of your pre-disability earnings.

Do I have it? It is a voluntary benefit - you must select it at the time of your New Hire enrollment or during Open Enrollment.
STD is offset or reduced by any regular pay, annual leave, or sick leave you receive while on STD. STD can last up to 22 weeks/6 months. Before STD expires, you must apply for Long-Term Disability.
For any disability occurring on or after January 1, 2019, donated leave will no longer reduce your STD benefit payment.
Short-Term Disability (STD) is administered by MetLife for ASRS and CORP members.

How to report a claim:
Contact Metlife at 1-866-264-5144 or via web at https://mybenefits.metlife.com/stateofarizona

Long-Term Disability

What is it? Long-Term Disability (LTD) is insurance that protects an employee from loss of income in the event that he or she is unable to work due to illness, injury, or accident for a long period of time.

Do I have it? Benefit eligible employees are automatically enrolled in one of the State's two LTD programs. Employee participation is mandatory.

Where am I enrolled? The employee's retirement system determines the LTD plan enrollment. Please see your retirement plan below to learn more.

POLICIES AND CLAIMS INFORMATION FOR LONG-TERM DISABILITY

ARIZONA STATE RETIREMENT SYSTEM (ASRS) PARTICIPANTS

Broadspire Services, Inc. is administered through ASRS.
Your LTD benefit will pay up to 66-2/3% of your income earnings during your disability as determined by Broadspire Services, Inc. and based on supporting medical documentation.
Your benefits may be subject to an offset based on Social Security payments, retirement benefits and other disability benefits.
LTD benefits can be paid until age 65 or until you are able to return to work after your disability as determined by Broadspire Services, Inc.
Medical documentation of your disability is required to continue your payment of benefits.
How to report a claim: Contact Central Human Resources, Benefits Unit at benefits@azadc.gov or by calling 602-255-2448 or 602-255-2447.

CORRECTIONS OFFICER RETIREMENT PLAN (CORP)

MetLife is the vendor for Long-term Disability administered through Benefit Options to non-ASRS participants.
Your LTD benefit may pay up to 66-2/3% of your monthly pre-disability earnings with a maximum benefit of $10,000 per month during your disability as determined by MetLife and based on supporting medical documentation.
How to report a claim: Contact Metlife at 1-866-264-5144 or via web at mybenefits.metlife.com/stateofarizona

Americans with Disabilities Act (ADA)

If you wish to pursue a possible accommodation through the ADA, you must complete a Request for Reasonable Accommodation, form 519-5, and submit recent HIPAA compliant medical documentation with detailed 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 listed below.

- Chad DeVerna, Employee Relations Manager (602) 542-3733
- Coral Martinez, Employee Relations Officer (602) 364-4984
- Matthew Waddell, Employee Relations Officer (602) 542-3800
- Nicole Turner, Employee Relations Officer (602) 364-1895
- Christine Natale, Employee Relations Officer (602) 255-2498
- Kari Stratton, Employee Relations Officer (602) 255-2447

Annual Leave Donations

State Personnel Rules allow employees who are experiencing a seriously incapacitating illness or injury themselves or with an immediate family member to request annual leave donations from other Department employees once you have exhausted your accrued annual and sick leave balances. Maximum duration for annual leave donations is six consecutive months from the last day worked. To request donations, submit an Agreement to Receive Annual Leave Contributions, Form 512-5 along with the appropriate certification from your physician to your Complex/Bureau HR Liaison.

Requests for Leave Without Pay

All absences from work, including Leave Without Pay, must be requested and approved in advance by submitting a Request for Leave, form 512-3(e).

To protect your rights and benefits you will need to ensure that you submit a request and obtain approval for Leave without Pay (LWOP) prior to exhausting your accrued leave, form 512-15(e) to preserve your employment status. All such requests must be submitted to your Warden, Bureau Administrator or Assistant Director (if applicable) for approval and must specify an approximate return date. If the leave is

due to a medical condition, ensure that HIPAA compliant medical documentation from your physician is included, which identifies the need for your absence, your health limitations, and an anticipated return to work date.

Per the State Personnel Rules, an agency head may consider the failure or inability of an employee to return to work on the first workday after an approved leave as a resignation.

Should you fail to request and receive advance approval for LWOP, or an extension prior to the expiration of an approved request, this will be considered as a resignation and you may be subject to separation from State service.

If your request for leave without pay is denied you are considered to be on unauthorized leave during that time and if you are unable to return to work you will be subject to further administrative action.

Medical Retirement:

For information on medical disability/retirement contact retirement@azadc.gov or by calling 602-255-2455 or 602-255-2456.

CONTACTS

MetLife **https://www.metlife.com/StateofArizona/** 602-255-5575 **Broadspire Services, Inc.** **https://www.azasrs.gov/content/long-term-disability** 1-877-232-0596 **Employee Assistance Program (EAP)** **https://wellness.az.gov/eap** **ADOA Benefits** **www.benefitoptions.az.gov** 602-542-5008	**ADCRR Benefits** Cathy Hernandez, Benefits Specialist 602-255-2448 Email: benefits@azadc.gov **ADCRR Retirement** Sandra Moreno, Retirement Specialist 602-255-2455 Karen Ray, Retirement Specialist 602-255-2456 Kelly Smith, Benefits Manager 602-255-2453 Email: retirement@azadc.gov **ADCRR Employee Relations** Chad DeVerna, Employee Relations Manager (602) 542-3733 Coral Martinez, Employee Relations Officer 602-364-4984 Matthew Waddell, Employee Relations Officer 602-542-3800 Nicole Turner, Employee Relations Officer 602 364-1895 Christine Natale, Employee Relations Officer 602 255-2498 Kari Stratton, Employee Relations Officer 602-255-2447