

Alaska Family Leave Act (AFLA) Family Medical Leave Act (FMLA) And Military Family Leave

*AFLA/FMLA leave should be applied for after any incapacity or treatment connected with inpatient care in a hospital, hospice or residential medical care facility; or a period of incapacity requiring absence of more than **three calendar days** from work, school or other daily activities that involves continuing treatment by a health care provider; or any period of incapacity due to pregnancy or for prenatal care.*

The Anchorage School District will grant job protected family and medical leave to eligible employees for any one of the following reasons:

- ◆ The birth of a child or the placement of a child with the employee for adoption or foster care; or
- ◆ In order to care for an immediate family member of the employee if such immediate family member has a serious health condition; or
- ◆ The employee's own serious health condition that makes the employee unable to perform the essential functions of their job.
- ◆ “Any qualifying exigency” arising out of the fact that the spouse, son, daughter, or parent of the employee is on active duty, or has been notified of an impending call to active duty status, in support of a contingency operation.
- ◆ To care for a covered service member who is recovering from a serious illness or injury sustained in the line of duty on active duty.

Eligibility

An employee is eligible for AFLA/FMLA if the employee has been employed by the Anchorage School District for at least 35 hours a week for at least six consecutive months or for at least 17.5 hours a week for twelve consecutive months immediately preceding the leave.

Length of Leave

Eligible employees are entitled to a total of 18 weeks of leave within 12-month period for:

- Pregnancy and birth of a son or daughter of the employee; or
- Placement of a child with the employee for adoption or foster care.

The right to take leave for these reasons expires on the date one year after the child's birth or placement of the child with the employee.

Eligible employees are entitled to a total of 18 weeks of leave within 24 month period or 12 weeks in a 12 month period for:

- The care of an employee's spouse, son, daughter, or parent with a serious health condition; or
- The employee's own serious health condition that makes the employee unable to perform the essential functions of their job.

Eligible employees are entitled to a total of 12 weeks of leave within 12-month period for:

- “Any qualifying exigency” arising out of the fact that the spouse, son, daughter, or parent of the employee is on active duty, or has been notified of an impending call to active duty status, in support of a contingency operation.

Eligible employees are entitled to a total of 26 weeks of leave within 12-month period for:

- An eligible employee who is the spouse, son, daughter, parent, or next of kin of a covered service member who is recovering from a serious illness or injury sustained in the line of duty on active duty.

Use of Accrued Leave

Accrued sick leave may be used by those approved for AFLA/FMLA subject to the restrictions in the employee's Negotiated Agreement.

If use of sick leave or personal leave is available to the employee to keep the employee in a paid status that leave will run concurrently with AFLA/FMLA.

Health Insurance Benefits

Health insurance coverage for employees on AFLA/FMLA shall be maintained for the period of time the employee is on approved Family Medical Leave, on the same basis as coverage is available to an employee who is actively at work. The District will pay the employer's portion of the medical expense while an employee is on AFLA/FMLA leave; the employee would still be responsible for any employee contribution.

Job Protection

Upon return from AFLA/FMLA leave, an employee must be restored to his or her original job, or to an "equivalent" job, which means virtually identical to the original job in terms of pay, benefits, and other employment terms and conditions.

Check List

- Your supervisor must sign and date the completed Family Medical Leave Form.
- Attach any Physician's Certifications, Workers Compensation Leave Option form, and Sick/Catastrophic Leave Bank Application requests to the FMLA form.
- 30-day advance notice of the need to take AFLA/FMLA leave when the need is foreseeable, for example a scheduled surgery or pregnancy
- Notice "as soon as practicable" when the need to take AFLA/FMLA leave is not foreseeable
- Send the completed paperwork to the Leave Specialist, Benefits Department.

If you have any questions regarding Alaska Family Medical Leave, Family Medical Leave or Military Family Leave, please check out our benefits website at www.asdk12.org/HR/Benefits/Leave. If you need to contact the Leave Specialist please call 742-4026 or by email at O'shea_Meghan@asdk12.org

Request for Family Medical Leave

Employee Last Name	Employee First Name	Employee SS#
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School/Unit	Position	Year of Hire
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Address & Phone Number _____
 during Family Medical Leave: _____
 (include zip code and area code) _____

Reason for Request

- 1. Birth of a child or the placement of a child for adoption or foster care.
(Physician or Practitioner Certification must include the date and type of birth.)
- 2. To care for an immediate family member with a serious health condition.
(Physician or Practitioner Certification for a Family Member must be submitted with FML Request)
- 3. Employee's own serious health condition.
(Physician or Practitioner Certification for Employee must be submitted with FML Request)

Leave Requested

- Consecutive Leave
- Intermittent or Reduced Leave Schedule
Note: Consecutive leave is required for Family Medical Leave for birth or placement of a child.

First Day of Leave: _____ Last Day of Leave: _____ Return to work date: _____

Sick Leave Bank Are you applying to the Sick Leave Bank? Yes No

If yes, attach a completed Leave Bank Application, HR Form #1385.

Please complete the Request for Extended Leave of Absence (HR#103) for unpaid leave used beyond the approved amount covered by the Family Medical Leave Act.

Employee Signature	Date
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Principal / Supervisor Signature	Date
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The Employee Signature and Principal/Supervisor Signature confirms acknowledgement of this leave request. Final approval for Family Medical Leave is dependent upon the employee's eligibility for Family Medical Leave. Leave is not approved until eligibility is verified and has been signed by the Leave Specialist.

Personnel use only

Tracking:

Meets Qualifications: Yes No

IFAS updated: _____

Benefits Department

Signature: _____

Date: _____

Physician or Practitioner Certification

Anchorage School District

Employee - Serious Health Condition

Employee SS#

Employee Last Name

Employee First Name

Diagnosis:

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Birth of a child: *Please state the date and type of birth: (If prior to birth, please provide estimated date of delivery)*

Date condition commenced: _____

Probable duration of condition: _____

Is in-patient hospitalization required? Yes No

Is employee able to perform work of any kind? Yes No

Does employee's serious health condition require intermittent or reduced leave use? Yes No

Explain regimen of treatment prescribed: *(Indicate number of visits, nature and duration of treatment. Include schedule of visits or treatment if it is medically necessary for the employee to be off work on an intermittent basis or to work less than the employee's normal schedule of hours per day or days per week.)*

Signature of Physician or Practitioner

Date

Print Name of Physician or Practitioner (include title)

Physician/Practitioner's Phone #

All documentation related to the employee's medical condition will be held in strict confidence and maintained in the employee's medical records file.

Please submit to:

Anchorage School District
Benefits Department - Leave Specialist
5530 E. Northern Lights Blvd.
Anchorage, Alaska 99504-3135

Physician or Practitioner Certification

Anchorage School District

Family Member - Serious Health Condition

Employee SS#	Employee Last Name	Employee First Name
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Patient's Name	Relationship
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Diagnosis:

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Date condition commenced: _____

Probable duration of condition: _____

Is employee needed to care for family member? Yes No

Estimate the period of time care is needed
or the employee's presence would be beneficial: _____

Signature of Physician or Practitioner:

Date

Print Name of Physician or Practitioner:

Physician/Practitioner's Phone #

TO BE COMPLETED BY THE EMPLOYEE

a. Explain the care you will provide:

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b. Estimate the time period: _____

c. Include a schedule if leave is to be taken intermittently or on a reduced leave schedule.

Employee signature:

Date:

All documentation related to the employee's medical condition will be held in strict confidence and maintained in the employee's medical records file.

Please submit to:

Anchorage School District
Human Resources Department
P.O. Box 196614
Anchorage, Alaska 99519-6614