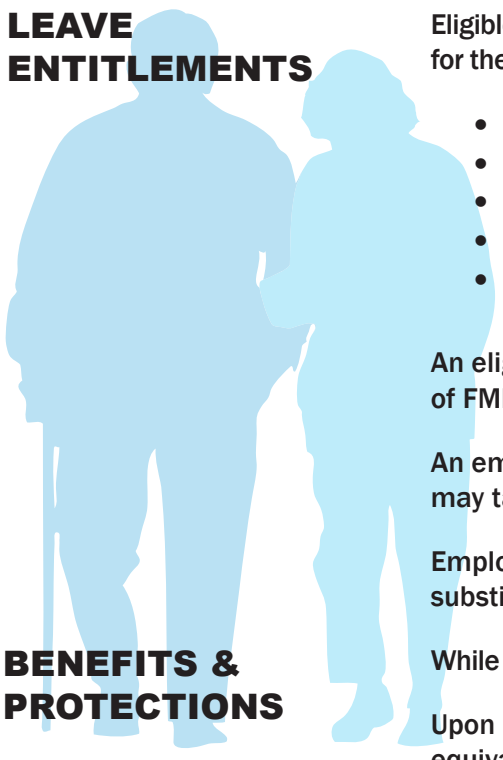
EMPLOYEE RIGHTS
UNDER THE FAMILY AND MEDICAL LEAVE ACT

THE UNITED STATES DEPARTMENT OF LABOR WAGE AND HOUR DIVISION



LEAVE ENTITLEMENTS

Eligible employees who work for a covered employer can take up to 12 weeks of unpaid, job-protected leave in a 12-month period for the following reasons:

- The birth of a child or placement of a child for adoption or foster care;
- To bond with a child (leave must be taken within 1 year of the child's birth or placement);
- To care for the employee's spouse, child, or parent who has a qualifying serious health condition;
- For the employee's own qualifying serious health condition that makes the employee unable to perform the employee's job;
- For qualifying exigencies related to the foreign deployment of a military member who is the employee's spouse, child, or parent.

An eligible employee who is a covered servicemember's spouse, child, parent, or next of kin may also take up to 26 weeks of FMLA leave in a single 12-month period to care for the servicemember with a serious injury or illness.

An employee does not need to use leave in one block. When it is medically necessary or otherwise permitted, employees may take leave intermittently or on a reduced schedule.

Employees may choose, or an employer may require, use of accrued paid leave while taking FMLA leave. If an employee substitutes accrued paid leave for FMLA leave, the employee must comply with the employer's normal paid leave policies.

BENEFITS & PROTECTIONS

While employees are on FMLA leave, employers must continue health insurance coverage as if the employees were not on leave.

Upon return from FMLA leave, most employees must be restored to the same job or one nearly identical to it with equivalent pay, benefits, and other employment terms and conditions.

An employer may not interfere with an individual's FMLA rights or retaliate against someone for using or trying to use FMLA leave, opposing any practice made unlawful by the FMLA, or being involved in any proceeding under or related to the FMLA.

ELIGIBILITY REQUIREMENTS

An employee who works for a covered employer must meet three criteria in order to be eligible for FMLA leave. The employee must:

- Have worked for the employer for at least 12 months;
- Have at least 1,250 hours of service in the 12 months before taking leave;* and
- Work at a location where the employer has at least 50 employees within 75 miles of the employee's worksite.

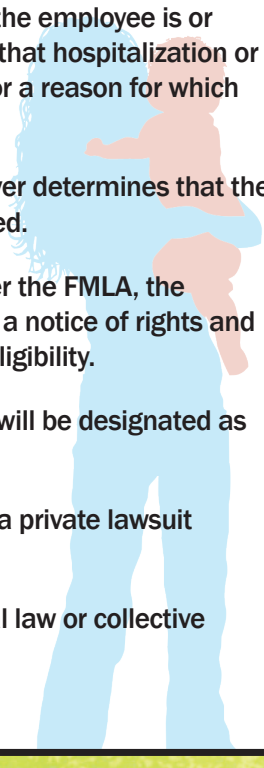
*Special "hours of service" requirements apply to airline flight crew employees.

REQUESTING LEAVE

Generally, employees must give 30-days' advance notice of the need for FMLA leave. If it is not possible to give 30-days' notice, an employee must notify the employer as soon as possible and, generally, follow the employer's usual procedures.

Employees do not have to share a medical diagnosis, but must provide enough information to the employer so it can determine if the leave qualifies for FMLA protection. Sufficient information could include informing an employer that the employee is or will be unable to perform his or her job functions, that a family member cannot perform daily activities, or that hospitalization or continuing medical treatment is necessary. Employees must inform the employer if the need for leave is for a reason for which FMLA leave was previously taken or certified.

Employers can require a certification or periodic recertification supporting the need for leave. If the employer determines that the certification is incomplete, it must provide a written notice indicating what additional information is required.



EMPLOYER RESPONSIBILITIES

Once an employer becomes aware that an employee's need for leave is for a reason that may qualify under the FMLA, the employer must notify the employee if he or she is eligible for FMLA leave and, if eligible, must also provide a notice of rights and responsibilities under the FMLA. If the employee is not eligible, the employer must provide a reason for ineligibility.

Employers must notify its employees if leave will be designated as FMLA leave, and if so, how much leave will be designated as FMLA leave.

ENFORCEMENT

Employees may file a complaint with the U.S. Department of Labor, Wage and Hour Division, or may bring a private lawsuit against an employer.

The FMLA does not affect any federal or state law prohibiting discrimination or supersede any state or local law or collective bargaining agreement that provides greater family or medical leave rights.

For additional information or to file a complaint:

1-866-4-USWAGE

(1-866-487-9243) TTY: 1-877-889-5627

www.dol.gov/whd

U.S. Department of Labor | Wage and Hour Division

WH1420 REV 04/16

Arizona Department of Corrections

EMPLOYEE RIGHTS, BENEFITS, and RESPONSIBILITIES WHILE ON LEAVE

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. 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. For specific information regarding any content in this handout, contact your Human Resources Liaison at (602) 771-5732. You are encouraged to keep apprised of changes and to consult your supervisor, the Occupational Health Unit and/or Complex/Bureau HR 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.

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 for questions concerning benefit premium statements. Keeping these payments timely will ensure confirmed coverage.

Short-Term Disability

Policy Holder: State of Arizona
Policy Number: 395211

Changes made to the Short-Term Disability benefits will be effective for a disability that occurs on or after January 1, 2015.

- Maximum duration of benefits will be 26 weeks if disabled due to an injury. For illness, 22 weeks if your benefits start on day 31 or 18 weeks if your benefits start on day 61. Benefits end after 26 weeks from the date of injury or illness.
- Benefit payment will be offset by 100% of any sick and annual leave paid to you after the benefit elimination period is exhausted.

How STD Works
If you elect Short-Term Disability (STD) insurance and MetLife determines you are unable to work due to illness, pregnancy, or a non-work-related injury. The STD benefits will pay up to 66-2/3% of your pre-disability earnings during your disability. The weekly minimum benefit is $67.31; the weekly maximum benefit is $897.43. There are no pre-existing conditions or limitations. You must meet the actively-at-work provision. Paid benefits will be offset after the benefit elimination period is exhausted by any sick and annual leave paid to you.

Application for STD benefits may be completed on line or by calling MetLife (866)-264-5144
Information: https://www.metlife.com/stateofarizona
Claims: https://mybenefits.metlife.com/stateofarizona

Long-Term Disability

You may be eligible for Long-Term Disability Benefits. These benefits begin after six months (180 consecutive days) of inability to work due to medical reasons. Contact information is as follows or you may contact your Human Resources Liaison at (602) 771-5732.

CORP Employees
https://mybenefits.metlife.com/stateofarizona or by telephone (866) 264-5144
Policy Holder: State of Arizona

ASRS Employees
The ASRS has contracted with Broadspire for administration of this LTD plan. To apply, please contact Human Resources for an LTD Packet.

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, 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.

- Wesley Elwell, Employee Relations Officer for the Northern Region (602) 255-2498
- Coral Martinez, Employee Relations Officer for the Southern Region (602) 364-4984

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 Division 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 system, 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.

Arizona Department of Corrections Rehabilitation and Reentry

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)*	EIN	JOB TITLE
SHIFT	INSTITUTION/FACILITY/BUREAU/UNIT	WORK TELEPHONE NUMBER *(area code)*
DATE FROM *(mm/dd/yyyy)*	DATE TO *(mm/dd/yyyy)*	

REASON FOR LEAVE

☐ Birth of my child or to bond with 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
☐ Military Caregiver Leave ☐ Qualifying Exigency Leave (*Both can be taken intermittently or on a reduced Work schedule)

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

FML ELIGIBLE

Hire Date _____ Employed by the state for at least 12 months? ☐ Yes If No →
Number of hours worked _____ Meets the 1,250 hour criteria? ☐ Yes If No →
Previous FML hours used? ☐ Yes ☐ No If yes, number of hours _____
Eligible for _____ FML weeks _____ FML hours
HRIS XT51 status ☐ Pending – FML record number _____
☐ 519-6 *(HRIS Input form)* **Updates Required by OHN** *(FML keyed into the HRIS Screen)*
☐ Ineligible for HRIS XT51 entry or 519-6 Changes

FML INELIGIBLE

☐ Ineligible – Insufficient months of work
☐ Ineligible – Insufficient hours worked
☐ FMLA entitlement exhausted for this 12 month Period.
FMLA eligibility renews on *(mm/dd/yyyy)* _____
HRIS XT51 Status ☐ Ineligible
FML record number _____
☐ 519-6 *(HRIS Input form)* Updates Not Needed

HROPs STAFF / DATE *(mm/dd/yyyy)*	AUDIT COMPLETED BY / DATE *(mm/dd/yyyy)*	DATE FML PACKET SENT / RECEIVED *(mm/dd/yyyy)*

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

HUMAN RESOURCES STAFF 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 to EA, ESA, or FML Coordinator for final signature.)*

☐ Yes ☐ No ☐ CHCP not received

WORK RELATED INJURY/ILLNESS ☐ Yes ☐

OCCUPATIONAL HEALTH UNIT COMMENTS

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	REQUEST APPROVED ☐ Yes ☐ No	DATE *(mm/dd/yyyy)*
DATE NOTIFICATION SENT TO EMPLOYEE *(mm/dd/yyyy)*		

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

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

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

OMB Control Number: 1235-0003
Expires: 8/31/2021

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. 29 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):

   _____

   _____

   _____

   _____

   _____

   _____

   _____

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.

_____

_____

_____

_____

_____

_____

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 Family Member's Serious Health Condition (Family and Medical Leave Act)

U.S. Department of Labor
Wage and Hour Division

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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):

_____

_____

_____

_____

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:

   _____

   _____

   _____

   _____

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**

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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, 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 & Reentry

1601 WEST JEFFERSON
PHOENIX, ARIZONA 85007
(602) 542-5497
www.azcorrections.gov

DOUGLAS A. DUCEY
GOVERNOR

DAVID SHINN
DIRECTOR

Donated Leave Applicant:

This cover letter serves to assist you with the submittal of a request to receive Donated Annual Leave (DAL).

- Complete and submit the Agreement to Receive Annual Leave Contributions 512-5(e) form to your HR Liaison (initial where indicated, complete sections with your personal information, complete your health care provider's name, complete address, and phone number, print your name, sign your name, and date).
- Attach documentation from your health care provider that includes your **diagnosis, prognosis**, **estimated return to work date**, and all other pertinent information. This is normally accomplished with the completion of a Health Status Report 519-3(e) and/or Certification of Health Care Provider for Employee.
- If the request is to care for a family member, the documentation for that family member must include his/her diagnosis, prognosis, your estimated return to work date, reason why you are required to assist the family member, and all other pertinent information. This is normally accomplished with the completion of a Certification of Health Care Provider for Family Member.
- If a need arises for you to continue be off work past the expiration of approved donated leave, you will need to submit an updated Health Status Report or Certification of Health Care Provider form showing your diagnosis, prognosis, estimated return to work date, and all other pertinent information **BEFORE** the expiration of your approved donated leave.

In order to receive DAL, you must have **exhausted all** of your available leave time. If the request is for an immediate family member, you must have exhausted all of your annual, holiday, comp leave and utilized 40 hours of sick leave (if applicable).

In order to be eligible to request DAL, your health care provider must indicate that you are required to be off work for a minimum of three (3) consecutive weeks.

If you are approved to receive DAL, you can view "Leave Activity" in the "YES" system to determine if employees have donated their annual leave to you.

Sincerely,
Human Resources

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 that if I am receiving Short Term Disability payments, those payments will be reduced by any annual, sick, or Donated Annual Leave (DAL) for which I received payment.

_____ 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)
4/11//16

ARIZONA DEPARTMENT OF CORRECTIONS

Leave Without Pay Employee Request
Personnel Rule R2-5A-C602

TO *(Warden/Bureau Administrator) (Last, First M.I.) (Please print)*	FACILITY/LOCATION/UNIT

FROM *(Employee name) (Last, First M.I.) (Please print)*	EMPLOYEE IDENTIFICATION NUMBER	JOB TITLE

TYPE OF LEAVE

☐ Military ☐ Maternity ☐ Personal ☐ Medical ☐ Educational

ANNUAL LEAVE	SICK LEAVE	COMP-TIME	HOLIDAY LEAVE

APPROXIMATE LEAVE WITHOUT PAY DATE *(mm/dd/yyyy)*	LAST DAY WORKED *(mm/dd/yyyy)*	APPROXIMATE/REQUESTED RETURN DATE *(mm/dd/yyyy)*

REASON FOR LEAVE

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

Forward to Warden or Bureau administrator whichever applies. Any request 80-hours or more will be forwarded to Employee Relations by the Warden or Bureau administrator for staffing with applicable Division Director.

COMMENTS

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

Distribution: Original – Warden or Bureau Administrator

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)*

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