ALASKA MARINE HIGHWAY
VESSEL OPERATIONS

Mail or Fax original form to:
DOT&PF – AMHS
AMHS Dispatch
7559 N. Tongass Highway
Ketchikan, AK 99901
Fax: 907 225-9398

UNFIT / FIT FOR DUTY FORM

EMPLOYEE – Please read and sign this portion only:

1. Once you are relieved of duty due to illness or injury - you **MUST** have this form filled out by a physician and submitted to the above AMHS office **within 72 hours (3 workdays).** Failure to submit this form after declaring unfit for duty will be considered unauthorized absence.
2. This form must be completed by your physician and submitted before any sick leave benefits will be paid; before you may return to work after an illness or injury; and for determining whether State Travel Authorization (TA) is applicable. **NO OTHER FORM WILL BE ACCEPTABLE.**
3. It is your responsibility to distribute copies of this form, fully complete and signed, to:

→ Original Copy to Dispatch/Crew Scheduling in Ketchikan
→ 1 copy to Harbor Adjusters 1900 W. Benson Blvd. Suite 101, Anchorage, AK 99517

This form is not used to determine Family and Medical Leave Act (FMLA) eligibility or entitlement. You must request a separate FMLA packet from Tech Services at (907) 465-4052.

Employee Signature: ______________________________ Date: ____/____/____

PHYSICIAN USE ONLY below this point -- **Required Information**:

Please identify the days below that the Alaska Marine Highway System (AMHS) employee will not be able to perform his or her duties. **DO NOT SPECIFY** to the end of the assignment if the employee can perform duties prior to that date.

This is to certify that I have examined this AMHS employee:

Employee Name: ______________________________ **SSN:** ________-____-________

In my professional opinion this AMHS employee's condition is such that:

(1) The employee is unfit for duty as of ____/____/____, for the following reason(s):

____

____

(2) (a) The employee will be fit for duty on ____/____/____

(b) The employee needs re-exam before fit for duty determination: Yes No

(c) Re-exam date scheduled: Yes date of exam ____/____/____ No

(3) Check appropriate box:

The employee may be transported by the vessel to change port.

Employee's medical condition requires transportation by airline to change port for necessary medical treatment.

The employee may not be transported at this time.

CLINIC INFORMATION:
Name: ______________________________
Address: ______________________________
Telephone No.: (_____) ________ - ____________

PHYSICIAN INFORMATION:
Name [printed]: ______________________________
Signature ______________________________
Date: ____/____/____ Tel. No.: (____) _______ - __________

*Dispatch Office: Fax copy to payroll at 907-465-2019