State of Alaska
Department of Transportation
& Public Facilities

ALASKA MARINE HIGHWAY SYSTEM

Mail or Fax original form to:
AMHS Dispatch
7559 North Tongass Highway
Ketchikan, AK 99901
Fax: 907 228-6873

UNFIT / FIT FOR DUTY FORM

EMPLOYEE – Please read and sign this portion only, USE THE CURRENT VERSION:

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 TRISTAR Risk Management, PO Box 240369 Anchorage, AK 99524-0369

This form may be used to determine eligibility for entitlements under the Family and Medical leave Act (FMLA) and/or Alaska Family Leave Act (AFLA). The DOA, DOP&LR, Payroll Services may need additional information to determine if FMLA/ AFLA entitlements are approved. This form must be used to communicate with Dispatch your work availability during FMLA and/or AFLA periods
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: _____ **Employee ID:** _____
(Do not enter the Social Security Number)

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 is or will be fit for duty on _____/_____/_____
OR
(b) The employee needs a reexamination before fit for duty determination:
Date if Re-examination: _____/_____/_____

(3) If employee is being treated by a physician in a port other than their change port, please 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: Name: _____
INFORMATION: Address: _____
Telephone No.: (_____) _____ - _____

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