



State of Alaska
Department of Transportation
& Public Facilities

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

ALASKA MARINE HIGHWAY SYSTEM

AMHS 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 Penser North America Inc. PO Box 241148 Anchorage, AK 99524-1148 Fax: 907-302-3803

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.: (____) _____ - _____