



# 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, USE THE CURRENT VERSION OF THIS FORM:**

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. However, this form must be used to inform Dispatch of work availability during FMLA.

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.: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_