THE NAVAJO NATION

JONATHAN NEZ | PRESIDENT MYRON LIZER | VICE-PRESIDENT

MEMORANDUM

TO : Division Directors, Department and Program Managers
EXECUTIVE BRANCH AND LEGISLATIVE BRANCHES

FROM : _____
Reycita Toddy, Delegated Human Resources Director
Department of Personnel Management

DATE : September 10, 2020

SUBJECT: FAMILY AND MEDICAL LEAVE PROCEDURES

Attached for your information and use is a copy of the revised Family and Medical Leave Procedures. These procedures outline the conditions under which an eligible employee may request time off without pay for a limited period with job protection and no loss of accumulated service, provided that the employee returns to work.

These procedures support and define the Family and Medical Leave policies as contained in the most recent Navajo Nation Personnel Policies Manual.

Should you have any questions, please contact the Department of Personnel Management at (928) 871-6330. Thank you.

CONCURRED:

Dr. Perphelia Fowler, Division Director
Division of Human Resources

Attachments

DISTRIBUTION

XC: Paulson Chaco, Chief of Staff, OPVP
LaShawna Tso, Chief of Staff, Office of the Speaker
Dr. Perphelia Fowler, Division Director, DHR
File

DEPARTMENT OF PERSONNEL MANAGEMENT
P. O. BOX 7080, WINDOW ROCK, ARIZONA 86515
PHONE NO: (928) 871-6330; FAX NO: (928) 871-6976; Website: www.dpm.navajo-nsn.gov

PROCEDURES
EXECUTIVE AND LEGISLATIVE BRANCHES
DEPARTMENT OF PERSONNEL MANAGEMENT

SECTION:	LEAVE ADMINISTRATION	NO. 03-X-003
SUBJECT:	FAMILY AND MEDICAL LEAVE PROCEDURES	RELEASE DATE: 10/01/96
CROSS REFERENCE:	NNPPM Section X.D Family and Medical Leave and C.1 Approved Leave without Pay	REVISION DATE: 08/28/20
REVIEW:	DEPARTMENT OF JUSTICE REVIEW	DOJ REVIEW DATE: 07/30/20

PURPOSE

To outline the conditions under which an eligible employee may request time off without pay for a limited period with job protection and no loss of accumulated service, provided that the employee returns to work. These procedures support and define the Family and Medical Leave policies of the Navajo Nation Executive and Legislative Branches as contained in the most current Navajo Nation Personnel Policies Manual.

APPLICABILITY

These procedures shall apply to all regular status (full-time) employees who have been employed with the Navajo Nation for at least one year, at the time the employee submits their request.

DEFINITIONS

Continuing Treatment: A period of incapacity (i.e., inability to work, attend school or perform other regular daily activities due to the serious health condition, treatment therefore, or recovery there from) of more than three consecutive calendar days, and any subsequent treatment or period of incapacity relating to the same condition, that also involves: 1) Treatment two or more times by a health care provider, by a nurse or physician's assistant under direct supervision of a health care provider, or by a provider of health care services (e.g., physical therapist) under orders of, or on referral by, a health care provider; or 2) Treatment

by a health care provider on at least one occasion which results in a regimen of continuing treatment under the supervision of the health care provider.

Family and Medical Leave: approved unpaid leave available to eligible employees for up to six months per year under particular circumstances that are critical to the life of a family. Leave may be taken in the following situations: the birth of the employee's child; the placement of a child with the employee for adoption or foster care; when the employee is needed to care for a child, spouse, or parent who has a serious health condition; or when the employee is unable to perform the functions of his/her position because of a serious health condition.

Health Care Provider: a doctor of medicine or osteopathy who is authorized to practice medicine or surgery, (as appropriate for the medical issue) by the State in which the doctor practices.

In loco parentis: persons with day-to-day responsibilities to care for and financially support a child.

Intermittent Leave: leave taken in intervals; recurrent periodical leave due to a single qualifying reason.

Parent: the biological parent of an employee or an individual who stood in loco parentis to an employee when the employee was a child. This includes an individual who assumed day-to-day responsibility for a child.

Reduced leave schedule: a leave schedule that reduces the usual number of hours per workweek, or hours per workday, of an employee.

Serious health condition: an illness, injury, impairment, or physical or mental condition that involves: a) Inpatient care (e.g. an overnight stay) in a hospital, hospice, or residential medical care facility, including any period of incapacity, or any subsequent treatment in connection with such inpatient care; or b) continuing treatment by a health care provider.

Son or daughter: a biological, adopted or foster child, a step child, a legal ward, or a child of a person standing in loco parentis (in place of a parent) who is: a) under 18 years of age; or b)18 years of age or older and incapable of self-care because of a mental or physical disability.

Spouse: a husband or wife as defined or recognized by Navajo Nation law.

ELIGIBILITY

Eligible employees can take up to 12 workweeks of unpaid leave during any 12-month period to attend to the serious health condition outlined below. These conditions can

affect the individual, parent, spouse, or child of the employee. Upon their return to work, it is expected that they will return to the same position with the same pay and benefits, but if that is not possible they will be placed in a position of equal value in terms of pay and benefits.

These procedures do not apply to:

- part-time workers who have worked fewer than 1,250 hours within the 12 months preceding the unpaid leave,
- time off to care for seriously ill elderly relative (other than parents) unless they were acting in loco parentis at the time the employee turned 18,
- time off to care for pets,
- time off to recover from a short-term or common illness like a cold, or to care for a family member of a short-term or common illness, and
- employees who need time off for routine medical care, such as checkups.

PROCEDURES

A. Family and Medical Leave (FML)

1. FML may be taken only in the following situations:
   a. upon the birth of the employee's child;
   b. Upon the placement of a child with the employee for adoption or foster care;
   c. when the employee is needed to care for his/her child, spouse, or parent who has a serious health condition; or
   d. when the employee is unable to perform the functions of his/her position because of a serious health condition.

FML is without pay and may be available to employees for up to six months in a 12-month period. The 12-month period is measured forward from the date an employee takes FML. The next 12-month period would begin the first time FML is taken after the completion of the prior 12-month period. *Example: Jane's FML begins on November 6, 2019 so her 12-month period is November 6, 2019 through November 5, 2020.*

The first three months of FML are nondiscretionary; if an employee requests leave consistent with the FML policies and procedures, the supervisor must approve the leave. The second three months of FML are discretionary and is subject to the supervisor's approval or disapproval.

B. Leave Requests

1. An Application for FML and a Personnel Action Form (PAF) must be completed and signed by the employee and submitted as far in advance as practicable to the immediate supervisor for proper approval.

2. When the need for leave is foreseeable such as the birth or adoption of a child, or planned medical treatment, the employee must submit an application for leave at least 30 calendar days before the leave is to begin.

3. Requests for FML must have sufficient medical certification as required in B.1-3 below.

4. A supervisor must provide a response (decision) within five (5) working days from receipt of the request for FML. If appropriate medical certification, or other required information is not provided by the employee, the supervisor must request this information, preferably in writing. An employee must provide the requested medical certification within 15 calendar days.

5. The supervisor is responsible for verifying that the employee has exhausted his/her accrued sick leave hours prior to approving the request for FML.

6. The supervisor is responsible for preparing and submitting a Start of Family and Medical Leave PAF to the Department of Personnel Management for processing.

7. If medically necessary for a serious health condition, leave may be requested on an "intermittent" basis or a "reduced leave schedule." However, if leave is requested on this basis, the Navajo Nation may require the employee to be assigned to another position which better accommodates a recurring period of absence or a part-time work schedule, provided the position has equivalent pay.

B. Medical Certification

1. For purposes of leave due to a serious health condition of the employee's child, spouse or parent, the certificate should include:
   a. the date on which the serious health condition commenced;
   b. the probable duration of the condition;
   c. the appropriate medical facts within the knowledge of the health care provider regarding the condition; and
   d. an estimate of the amount of time that the employee is needed to provide such care.

2. If leave is being requested for an employee's own serious health condition, in addition to B.1.a-d above, the certification must also include a statement that the employee is unable to perform the functions of his/her position.

3. In the case of certification for recurrent or periodical leave (intermittent), or leave on a reduced leave schedule for planned and/or unanticipated medical treatment of a related serious health condition; leave for the recovery from treatment; leave for recovery from a serious health condition; or leave to provide care or psychological comfort to an immediate family member with a serious health condition, the dates on which such treatment is expected to be given and the duration of such treatment must be stated.

C. When the leave is for the birth or placement of a child, an employee must submit an application for leave at least 30 calendar days before leave is to begin.

1. Entitlement to FML for a birth or placement expires at the end of 12 months after the date of birth or placement. For example: If a child is born November 4, leave must be taken by November 4 of the following year.

2. Spouses who are both employed by the Navajo Nation are entitled to a total of six months of leave (rather than six months each) for the birth or adoption of a child or for the care of a sick child.

D. If leave is unforeseeable, the employee must provide notice to the supervisor as soon as practicable. If medical certification has not been provided, it must be submitted within 15 calendar days of notice from the supervisor. Failure to provide appropriate medical certification within the required period may result in the denial of or delay in the use or approval of family and medical leave.

E. Reporting Requirements:

1. Employees on FML will be required to report to the immediate supervisor periodically regarding their leave status and intention to return to work.

2. If an employee fails to return to work after leave expires or give notice of intent not to return to work it shall be deemed a resignation unless an extension is granted.

F. Extension of Family and Medical Leave

1. An employee who requests an extension of FML due to the continuation, recurrence, or onset of his/her own serious health condition, or due to the serious health condition of the employee's spouse, child or parent must submit a written request for extension to the employee's supervisor prior to the end of the initial FML period.

2. This request should be made as soon as the employee realizes that he/she will not be able to return at the expiration of the leave period.

3. Extension requests may be taken as outlined under Section X.C.1. Approved Leave Without Pay. Leave without pay may not exceed 15 consecutive working days, which may be granted by the supervisor. Requests for leave without pay exceeding 15 consecutive working days must be supported by a written recommendation by the supervisor, and must be approved by the Division Director. Such leave may not exceed thirty (30) calendar days within the leave year.

G. Return from Leave

1. An employee must complete and submit a Notice of Intention to Return from FML before he/she can be returned to active status.

2. If an employee wishes to return to work prior to the expiration of leave, the employee must submit a Notice of Intention to Return from FML to his/her supervisor at least five (5) working days prior to an employee's planned return.

REQUIRED FORMS

Personnel Action Form (PAF): Start of FML and End of FML
Application for Family and Medical Leave
Response to Request for Family and Medical Leave
Certification of Health Care Provider for Employee's Serious Health Condition
Certification of Health Care Provider for Family Member's Serious Health Condition
Notice of Intention to Return from Family and Medical Leave

APPLICATION FOR FAMILY AND MEDICAL LEAVE (FML)

Name: _____ Department: _____

Current Address: _____

_____

Date of Anticipated Leave: _____

Expected Date of Return from Leave: _____

Reason for Leave (Explain): _____

_____

_____

NOTE:	*A leave request based on an employee's serious health condition or the serious health condition of an employee's spouse, child or parent must be accompanied by a verifying medical certification from a physician.* *You are required to submit this form in a timely manner. Failure to provide a complete and sufficient medical certification may result in a denial of your FML request.*

I hereby authorize my supervisor to contact my physician, if necessary.

I understand that a failure to return to work at the end of my leave period may be treated as a resignation unless an extension has been agreed upon and approved in writing by my supervisor.

Employee's Signature: _____ Date: _____

APPROVED BY:

Supervisor's Signature _____ Date _____

Certification of Health Care Provider for Employee's Serious Health Condition Family and Medical Leave (FML)

TO BE COMPLETED BY THE EMPLOYER

INSTRUCTIONS TO THE EMPLOYER: The Navajo Nation Personnel Policy Manual (NNPPM) Section X.D. provides that an employer may require an employee seeking FML 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 this section before giving this form to your employee. The Department of Personnel Management maintains records and documents relating to medical certifications and re-certifications of employees for FML purposes as confidential medical records in a separate file.

Employer name and contact:_____

Employee's job title:_____ Regular work schedule:_____

Employee's essential job functions:_____

_____

Check if job description is attached: ☐

TO BE COMPLETED BY THE EMPLOYEE

INSTRUCTIONS TO THE EMPLOYEE: Please complete this section before giving this form to your medical provider. The FML permits an employer to require that you submit a timely, complete and sufficient medical certification to support your request for FML due to your own serious health condition. Your employer must give you at least 15 calendar days to return this form.

Employee name: _____
(First) (Middle) (Last)

TO BE COMPLETED BY THE HEALTH CARE PROVIDER

INSTRUCTIONS TO THE HEALTH CARE PROVIDER: Your patient has requested leave under the FML. Please answer, fully and completely all applicable parts. Several questions seek a response as to the duration of a condition, treatment, etc. Be as specific as you can. Limit your response to the condition for which the employee is seeking leave. 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, hospices 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 years 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 on Page 1 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 certification, 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 treatments 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 _____

ADDITIONAL INFORMATION: Identify question number with your additional answer:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____ _____
Signature of Health Care Provider Date

Certification of Health Care Provider for Family Member's Serious Health Condition Family and Medical Leave (FML)

TO BE COMPLETED BY THE EMPLOYER

INSTRUCTIONS TO THE EMPLOYER: The Navajo Nation Personnel Policy Manual (NNPPM) Section X.D. provides that an employer may require an employee seeking FML 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 this section before giving this form to your employee. The Department of Personnel Management maintain records and documents relating to medical certifications and re-certifications of employees for FML purposes as confidential medical records in a separate file.

Employer name and contact:_____

TO BE COMPLETED BY THE EMPLOYEE

INSTRUCTIONS TO THE EMPLOYEE: Please complete this section before giving this form to your family member or his/her medical provider. The FML permits an employer to require that you submit a timely, complete and sufficient medical certification to support your request for FML to care for a covered family member with a serious health condition. Your employer must give you at least 15 calendar days to return this form.

Employee 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's Signature Date

TO BE COMPLETED BY THE HEALTH CARE PROVIDER

INSTRUCTIONS TO THE HEALTH CARE PROVIDER: The employee listed above has requested leave under FML to care for your patient. Please answer, fully and completely all applicable parts. Several questions seek a response as to the duration of a condition, treatment, etc. Be as specific as you can. Limit your response to the condition for which the employee is seeking leave. Please be sure to sign the form on the last page.

Provider'sname and business address:_____

Typeof 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, hospices 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 years 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:_____

PART B: Amount of Leave Needed. When answering these questions, keep in mind 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:

3. Will patient require care on an intermittent or reduce schedule basis, including any time for recovery? No ☐ Yes ☐

   Estimate the hours the patient will need on an intermittent basis, if any:

   _____ hour(s) per day; _____ days per week from _____ through _____

_____ _____

Signature of Health Care Provider Date

Employer Response to Employee Request for Family and Medical Leave

Date: _____

To: _____
(Employee's Name)

From: _____
(Supervisor's Name/Position Title)

Subject: Request for Family and Medical Leave

On _____, you notified me of your need to take family medical leave due to:
(date)

- ☐ The birth of your child, or the placement of a child with you for adoption or foster care; or
- ☐ A serious health condition that makes you unable to perform the essential functions of your job; or
- ☐ A serious health condition affecting your ☐ spouse, ☐ child, ☐ parent for which you are needed to provide care for.

You notified me that you need this leave beginning _____ *(insert date)* and that you expect leave to continue until on or about _____.
(date)

Except as explained below, you have right under the FML for up to 6 months of unpaid leave in a 12 month period for the reasons listed (that the first 3 months are nondiscretionary, the second 3 months are discretionary). Also, your health benefits must be maintained during any period of unpaid leave under the same conditions as if you continued to work, and you must be reinstated to the same or an equivalent job with the same pay, benefits, and terms and conditions of employment on your return from leave.

This is to inform you that *(check appropriate boxes, explain where indicated).*

1. You are ☐ eligible ☐ not eligble for leave under the Family and Medical Leave Policies.

2. You will be required to furnish medical certification of a serious health condition. You must furnish certification by _____ (insert date) (must be at least 15 calendar days after you are notified of this requirement).

SAMPLE

THE NAVAJO NATION
PERSONNEL ACTION FORM

Employee Position I.D. No.

DPM USE ONLY

☐ Employment Notice	■ Change Notice	☐ Termination Notice	Effective Date: October 1, 2019

Employee Name (Last, First Middle)	Mailing Address (City, State, Zip Code)	Social Security Number
Doe, John Yazzie		000-00-0000

Census Number	Marital Status	Gender	Date of Birth	Ethnic Code	Worksite
					Window Rock, AZ

Division /Department	Department Number	Business Unit Number
DHR / Department of Personnel Management	022	000000.0000

Position Title	Class Code	Grade Step	Hourly Rate	Per Annum
Administrative Assistant	1260			

Remarks : Start of Family and Medical Leave (FML), Not to Exceed: mm/dd/yyyy

Employee Signature — Date

UNAVAILABLE FOR SIGNATURE

Department Acceptance — Date

REQUIRED

Department Release — Date

Department of Personnel Management — Date

Type of Termination: ☐ Resignation ☐ Discharge ☐ Layoff

This section must be completed to ensure that all Tribal monies/property during employment have accounted for by the Financial Services Department and the following NN Departments or Offices

Cashiers Ofc		EE Benefits	
Accts Rec		EE Housing	
P-Card Sec		Fleet Mgmt	
Travel Adv		Property	
Credit Svcs		Retirement	
		Veterans	

Clearance by initial from each section/departments.

Type of Action: Start of Family and Medical Leave (FML)

Notice Type: Change

Family and medical leave of absence is approved unpaid leave available to eligible employees for up to six months per year under particular circumstances that are critical to the life of a family. All regular status employees who have been employed with the Navajo Nation for one year are eligible for FML. The application for FML, including the required forms must be completed and signed by the appropriate individuals. The first three months of leave are non-discretionary; if the leave is requested consistent with these policies, the supervisor must approve the leave. For assistance, please refer to the FML procedures available on the DPM website at www.dpm.navajo-nsn.gov, or contact the Employee Relations Section/DPM.

ATTACHMENTS & SUPPORTING DOCUMENTS

- ☐ Application for Family and Medical Leave
  - ☐ Employer Response to Employee Request for Family and Medical Leave
  - ☐ Certification of Physician or Practitioner - Original
  - ☐ Medical Certification Statement (Employee's Own Serious Illness) - Optional
  - ☐ Medical Certification Statement (Illness of Employee's Family Member) - if applicable

PAF REQUIREMENTS

- ☐ Employee's Signature is preferred but not required. If the employee is unavailable, the PAF must state "Unavailable for Signature"
- ☐ Department Acceptance Signature & Date
- ☐ Not to Exceed Date (shall not exceed the the NN fiscal year end date)

OTHER REQUIREMENTS

- ☐ If the position is externally funded, verification from Contract Accounting/OOC is required prior to submitting the PAF to the DPM.

Notice to Return from Family and Medical Leave

Name: _____

Supervisor: _____

Date Leave Commenced: _____

Date of Planned Return: _____

I understand that my return to employment is subject to the following conditions:

1. Each employee must provide a written certification from his or her health provider that the employee is able to resume working.

2. Every attempt will be made to restore an employee returning from leave to his or her original position. If the employee's original position is unavailable, the employee will be placed in an equivalent position with equivalent pay and benefits.

3. An employee returning from family and medical leave shall not be entitled to the accrual of any seniority or employment benefits during the period of leave.

_____ _____

Employee's Signature Date

♦ ♦ ♦

SAMPLE

THE NAVAJO NATION PERSONNEL ACTION FORM

Employee Position I.D. No.

DPM USE ONLY

☐ Employment Notice	■ Change Notice	☐ Termination Notice	Effective Date: October 1, 2019

Employee Name (Last, First Middle)	Mailing Address (City, State, Zip Code)	Social Security Number
Doe, John Yazzie		000-00-0000

Census Number	Marital Status	Gender	Date of Birth	Ethnic Code	Worksite

Division /Department	Department Number	Business Unit Number
DHR / Department of Personnel Management	022	000000.0000

Position Title	Class Code	Grade Step	Hourly Rate	Per Annum
Administrative Assistant	1260			

Remarks : End of Family and Medical Leave

Employee Signature — Date

UNAVAILABLE FOR SIGNATURE

Department Acceptance — Date

REQUIRED

Department Release — Date

Department of Personnel Management — Date

Type of Termination: ☐ Resignation ☐ Discharge ☐ Layoff

This section must be completed to ensure that all Tribal monies/property during employment have accounted for by the Financial Services Department and the following NN Departments or Offices

Cashiers Ofc		EE Benefits	
Accts Rec		EE Housing	
P-Card Sec		Fleet Mgmt	
Travel Adv		Property	
Credit Svcs		Retirement	
		Veterans	

Clearance by initial from each section/departments.

Type of Action: End of Family and Medical Leave

Notice Type: Change

Pursuant to the Navajo Nation Personnel Policies Manual ("NNPPM"), X.D.4.(d). A medical certification is required to resume work. Upon return from family and medical leave, an employee shall return to the same position and their annual and sick leave accruals will resume. An employee's failure to return to work after the duration of approved family and medical leave and any other authorized leave, shall be deemed a resignation.

ATTACHMENTS & SUPPORTING DOCUMENTS

- ☐ Medical certification to return to work - Original
  - ☐ Date cleared to return to work
- ☐ Depending on the requirements of the department, may be required to complete a physical examination

PAF REQUIREMENTS

- ☐ Employee's Signature is preferred but not required. If the employee is unavailable, the PAF must state "Unavailable for Signature"
- ☐ Department Acceptance Signature & Date

OTHER REQUIREMENTS

- ☐ If the position is externally funded by a contract/grant, prior verification from Contract Accounting/OOC is required.