Physician's Certificate

FOR OFFICE USE ONLY

Toll-Free: (800) 821-2251
alaska.gov/drb

Division of Retirement and Benefits
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Juneau, AK 99811-0203

Juneau: (907) 465-4460
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Public Employees' Retirement System (PERS)
Teachers' Retirement System (TRS)
Alaska Cost-of-Living Allowance

MEMBER INFORMATION

NAME (LAST / FIRST / M.I.)	
TELEPHONE NUMBER	EMAIL ADDRESS
RETIREMENT IDENTIFICATION NUMBER (RIN)	DEPARTURE DATE FROM ALASKA

I certify that I understand that **to receive the Alaska Cost of Living Allowance (COLA)**, I may be absent from the state **due to an illness** for a period not to exceed six months from date of departure. I understand that my eligibility for COLA under this provision is an exception to the requirements under AS 39.35.480 or AS 14.25.142, which prohibit my absence from the state for a continuous period exceeding 90 days. I am providing certification by a licensed physician that my absence from the state is required due to illness.

I also certify that my principle domicile remains in Alaska and I intend to return to Alaska after my illness is resolved. **I understand that if I establish a pattern of absence from the State for more than 90 days on a recurring basis I will be asked to provide information as outlined under 2 AAC 35.240 to confirm my eligibility for this benefit.**

In completing this medical certification, I acknowledge that a person who knowingly makes a false statement, or falsifies or permits to be falsified a record of the retirement system in an attempt to defraud the system is guilty of a class A misdemeanor, which, upon conviction, is punishable by a fine of not more than $500.00 or imprisonment for not more than twelve months or both.

I also acknowledge that a person who obtains funds and/or benefits by deception may be subject to prosecution for other crimes, including theft, which may be charged as misdemeanors or felonies with potential fines and penalties including imprisonment. I also acknowledge that a person who obtains funds and/or benefits from the system unlawfully may also be required to make restitution.

SIGNATURE	DATE

PHYSICIAN

I certify that I am a physician licensed to practice and I am providing this certification to the Plan Administrator to establish that my patient, listed above, must seek temporary medical attention outside of Alaska as a result of an illness.

I further certify that the illness will require continuous absence from the State of Alaska for a period of _____ months. The absence should commence_____.

SIGNATURE OF CERTIFYING PHYSICIAN	DATE
PRINTED NAME OF PHYSICIAN	TELEPHONE NUMBER
ADDRESS (STREET OR P.O. BOX)	

CITY	STATE	ZIP+4