

COASTAL PLAIN AREA EOA, INC.

FAMILY AND MEDICAL LEAVE REQUEST

Employee Number: _____ Date: _____

Name: _____ Title/Position: _____

Department: _____ Reports To: _____

Status: Full Time Part Time Temporary

Hire Date: _____

I request family medical leave for one or more of the following reasons:

Because of the birth of my child and in order to care for him or her. Attach Physician's Statement specify leave start and ending dates.

Expected date of birth _____ Actual date of birth (if applicable) _____

Because of the placement of a child with me for adoption or foster care.

Date of placement _____ Attach appropriate documentation.

Leave to start _____ Expected return date _____

In order to care for my spouse, child, or parent, who has a serious health condition. Attach appropriate documentation.

Leave to start _____ Expected return date _____

For a health condition that makes me unable to perform my job. Documentation supporting the qualifying event from attending Physician specifying dates of leave, must be attached to your request for Family Medical Leave.

Leave to start _____ Expected return date _____

Have you taken family or medical leave in the past twelve (12) months?

Yes No If yes, how many days? _____

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I understand and agree to the following:

1. I have been employed by this Agency for at least twelve (12) months.
2. During the previous 12 months I have worked at least 1,250 hours.
3. If I fail to return after my approved leave for reasons other than my original request, and have exhausted the maximum amount of Family and Medical leave, I will be responsible for the Medical Insurance Premiums.
4. This leave may be unpaid, unless it is Agency Policy to be paid, or payment may occur under an Agency Disability or other insurance plans under which I may be covered.
5. I will be required to use my annual, personal and sick leave as part of my 12 weeks of leave, except in cases of extended Workers' Compensation.
6. After the completion of my approved leave, if I do not return to work or contact the Personnel Director on or before my expected date of return, the Agency will assume that I abandoned my job.

Employee Signature _____ Date _____

Leave Approval: _____

Immediate Supervisor _____ Date _____

Program Director _____ Date _____

Executive Director _____ Date _____

Personnel Director _____ Date _____

Revised 7/27/01

Coastal plain Area economic Opportunity Authority, Inc.
Family and Medical Leave Act Form

Personnel Policies & Procedures - (Page 34, Section D) Family and Medical Leave

An employee, in accordance with the provisions of the Family and Medical Leave Act of 1993, may request up to twelve (12) weeks of paid or unpaid leave. The Agency will maintain health insurance coverage; however the employee will be responsible for the payment of his/her portion. If the employee family fails to pay his/her portion the insurance will be discontinued.

The Family Medical Leave Request Form must be completed by the employee, or their representative, with all evidence supporting the need for Leave, and forwarding to the Personnel Director. The Leave must be approved by the executive Director, who will notify the appropriate Department Head of the decision.

YOUR RIGHTS UNDER THE FAMILY AND MEDICAL LEAVE ACT OF 1993

FMLA required covered employers to provide up to 12 weeks of unpaid, job related leave to eligible employees for certain family and medical reasons. Employees are eligible if they have worked for a covered employer for at least one year, and for 1,250 hours over the previous 12 months, and if there are at least 50 employees within 75 miles.

Reasons for taking leave:

Unpaid leave must be granted for any of the following reasons:

- 1) to care for employee's child after birth, or placement for adoption or foster care;
- 2) to care for employee's spouse, son or daughter, or parent, who has a serious health condition; or
- 3) for a serious health condition that makes the employee unable to perform the employee's job.

At the employee's or employer's option, certain kinds of paid leave maybe substituted for unpaid leave.

Advance Notice and Medical Certification:

The employee may be required to provide advance notice and medical certification. Taking leave may be denied if requirements are not met.

- 1) The employee ordinarily must provide advance 30 days notice when the leave is "foreseeable."
- 2) An employer may require medical certification to support a request for leave because of a serious health condition, and may require second or third options (at the employer's expense) and a "fitness for duty" report to return to work.
- 3) For the duration of FMLA leave, the employer must maintain the employee's health coverage under any "group health plan."
- 4) Upon return from FMLA leave, most employees must be restored to their original or equivalent positions with equivalent pay, and other employment terms.
- 5) The use of the FMLA leave cannot result in the loss of any employment benefit that, accrued prior to the start of an employee's leave.

Unlawful Acts by Employers:

FMLA makes it unlawful for any employer to:

- 1) interfere with, restrain, or deny the exercise of any right provided under FMLA;
- 2) discharge or discriminate against any person for opposing any practice that is unlawful by FMLA or for involvement in any proceeding under or relating to FMLA.

Enforcement:

- 1) The U. S Department of Labor is authorized to investigate and resolve complaints of violations.
- 2) An eligible employee may bring a civil action against an employer for violations.

FMLA does not affect any Federal or State law prohibiting discrimination, or supersede any State or local law or collective bargaining agreement which provides greater or medical leave rights.

For Additional Information:

Contact the nearest office of the Wage and Hour Division, listed in most telephone directories under U.S. Government, Department of Labor.

U.S. DEPARTMENT OF LABOR
EMPLOYMENT STANDARDS ADMINISTRATION
WAGE AND HOUR DIVISION
WASHINGTON, D.C. 20210

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INSURANCE PAYMENTS

During the period of Family and Medical Leave the employee is responsible for the payment of their portion of health, dependent coverage, and all elective insurance such as: dental, vision, life, cancer, and short term disability.

If the employee is not being paid during their approved leave of absence, payment for insurance must be submitted to the Central Office, by Friday, after each payroll. If payment is not received by this date, your dependent coverage, and other elective insurance products will be canceled.

I certify I have read and understand the above policy regarding insurance payment during Family and Medical Leave.

Employee Signature

Date

Witness

Date