South Miami CritiCare, Inc.

Family and Medical Leave Act

Company Policy & Procedure

This is an overview of a proposed company Policy & Procedure that addresses the FMLA.

Policy:
It is the policy of South Miami CritiCare to comply with all the requirements of the Family and Medical Leave Act (FMLA). Together with Company Policies, the FMLA provides up to 12 weeks of unpaid, job-protected leave to eligible employees for the following reasons:

- The birth of a child, or placement of a child with you for adoption or foster care;
- Your own serious health condition;
- Because you are needed to care for your spouse, child or parent due to serious health condition;
- Because of a qualifying exigency arising out of the fact that your spouse, son or daughter or parent is on covered active duty or call to covered active duty status with the Armed Forces;
- Because you are the spouse, son or daughter, parent or next of kin of a covered servicemember with a serious injury or illness.

Procedure:
Employees have certain Rights and Responsibilities as spelled out by the act and is also guided by company policy. For more information, visit the website: https://www.dol.gov/whd/fmla/index.htm to make sure you qualify and to learn more about the requirements. Once you have decided to request FMLA absence, use the attached form to give notice as soon as you can.

Eligibility:
To qualify under the FMLA, you must have been employed for at least 12 months and have worked 1250 hours in the prior 12 months to be eligible for up to 12 weeks of unpaid, job-protected leave. FMLA also includes a special leave entitlement to care for a covered servicemember during a single 12-month period. Discuss this if applicable with your employer representative.

Giving Notice:
FMLA requires a minimum of 30 days advanced notice when the need is foreseeable. The nature of our work as Emergency Healthcare Providers is to ensure coverage is scheduled two-months in advance. You are asked to make your notice as soon as possible to limit any disruption in scheduling. Use the FMLA Employee Notice Form to request FMLA Leave. Complete the form and submit it to your Medical Director or the PMO.

Employer Responsibility:
SMCC complies with all the requirements of the FMLA. All the benefits that are afforded to you as an employee as part of our group benefits plans will be preserved while you are on leave as though you were still at work. For benefits that you have elected and are paying for, you will still be responsible for those costs. Company policy allows you to use accrued paid time off at a rate you specify to continue compensation while not working and on leave. You will receive written notice within five business days of making your request for FMLA leave indicating approval or not. If approved, you may have to still meet certain certification requirements which will be indicated on the approval for which you will be allowed fifteen (15) days to respond.

Employee Notice

The following form is provided for employees to request a leave of absence under the Family and Medical Leave Act (FMLA). Employees have certain Rights and Responsibilities as spelled out by the act and is also guided by company policy. For more information, visit the website: https://www.dol.gov/whd/fmla/index.htm

Eligibility: You must have been employed for at least 12 months and have worked 1250 hours of in the prior 12 months to be eligible for up to 12 weeks of unpaid, job-protected leave. FMLA also includes a special leave entitlement to care for a covered servicemember during a single 12-month period. Company policy allows you to use accrued paid time off at a rate you specify to continue compensation while not working and on leave.

Notice: FMLA requires a minimum of 30 days advanced notice when the need is foreseeable. The nature of our work as Emergency Healthcare Providers is to ensure coverage is scheduled two-months in advance. You are asked to make your notice as soon as possible to limit any disruption in scheduling.

Requested By:	
Date of Request:	
Amount of Time Requested:	
Proposed Start Date:	
Proposed End Date:	
Payment Election: (check one, fill in rate if selected)	☐ Unpaid leave ☐ Paid Leave using all paid time off available at a rate of ____hours per week
Reasoning for Request: (check one, check blank if selected)	☐ The birth of a child, or placement of a child with you for adoption or foster care; ☐ Your own serious health condition; ☐ Because you are needed to care for your ___spouse, ____child, ___parent due to serious health condition; ☐ Because of a qualifying exigency arising out of the fact that your ___spouse, ___son or daughter, ___parent is on covered active duty or call to covered active duty status with the Armed Forces; ☐ Because you are the ___spouse, ___son or daughter, ___parent, ___next of kin of a covered servicemember with a serious injury or illness.

Employee Signature: _____ **Date:** _____