University of Montevallo

Application for Family Medical Leave

Submit To: Mark Bolton
Manager of Employee Benefits
Station 6055, Puryear House
Montevallo, AL 35115
665-6055 boltonmw@montevallo.edu

From:

_____ _____
Employee Date of Application

_____ _____
Department Supervisor

Reason for Request

_____ Sickness of Self _____ Care of Newborn Child* _____ Placement of Child in Adoption or Foster Care*
_____ Sickness of Spouse _____ Sickness of Child _____ Sickness of Parent (Does not include in-laws)

Beginning Date of Leave _____ Anticipated Date of Return _____

EMPLOYEES RETURNING FROM A FAMILY MEDICAL LEAVE ABSENCE MUST NOTIFY HUMAN RESOURCES UPON RETURN TO CAMPUS ON THE DAY THAT REGULAR DUTY RESUMES. Email may be sent to boltonmw@montevallo.edu

Overstaying a leave without proper notification and approval, or seeking and accepting other employment without previous authorization, constitutes an automatic resignation and subsequent loss of benefits. If approved for Family Medical Leave, I understand that all sick leave, compensatory time, and vacation accruals must be first applied to Family Medical Leave (per UM policy) and that I will not earn vacation or sick leave while in non-pay status.

During my absence I understand that I must continue to complete my monthly leave reports and electronically forward them to my supervisor for approval. If I am unable to complete my reposts due to incapacitation, I authorize my supervisor to complete and submit my reports in my stead.

I understand that as long as I am on paid leave, the deductions for benefits will continue and that if I am no longer on paid leave, I must make a payment by the 5th of each month equal to the amount normally deducted from my pay. I also understand that any increase of premiums or changes in plan would apply. If I choose not to return to my employment at the University of Montevallo at the end of the approved period, I will repay the University's portion of all benefits provided on my behalf for the entire period of unpaid Family Medical Leave. All payments will be payable to the University of Montevallo and submitted to the Office of Human Resources at Station 6055.

I understand the requirements regarding Family Medical Leave and I certify that the above information is true and correct.

Requested by: _____ Reviewed by: _____
Employee Signature Manager of Employee Benefits

Distribution: The situation listed above qualifies for Family Medical Leave.

Employee: _____ Supervisor: _____

Payroll: _____ Dean/Director: _____

Vice President: _____

Human Resources Use Only: Date Leave Began: _____ Date Leave Ended: _____

Leave for this reason may be taken only during the first 12 months following birth, adoption or placement of the child.

Last update 4/19/11

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

U.S. Department of Labor
Wage and Hour Division

U.S. Wage and Hour Division

OMB Control Number: 1235-0003
Expires: 2/28/2015

SECTION I: For Completion by the EMPLOYER

INSTRUCTIONS to the EMPLOYER: The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA 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 Section I before giving this form to your employee. Your response is voluntary. While you are not required to use this form, you may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. §§ 825.306-825.308. Employers must generally maintain records and documents relating to medical certifications, recertifications, or medical histories of employees created for FMLA purposes as confidential medical records in separate files/records from the usual personnel files and in accordance with 29 C.F.R. § 1630.14(c)(1), if the Americans with Disabilities Act applies.

Employer name and contact: _____

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

Employee's essential job functions: _____

_____

Check if job description is attached: _____

SECTION II: For Completion by the EMPLOYEE

INSTRUCTIONS to the EMPLOYEE: Please complete Section II before giving this form to your medical provider. The FMLA permits an employer to require that you submit a timely, complete, and sufficient medical certification to support a request for FMLA leave due to your own serious health condition. If requested by your employer, your response is required to obtain or retain the benefit of FMLA protections. 29 U.S.C. §§ 2613, 2614(c)(3). Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA request. 20 C.F.R. § 825.313. Your employer must give you at least 15 calendar days to return this form. 29 C.F.R. § 825.305(b).

Your name: _____
First Middle Last

SECTION III: For Completion by the HEALTH CARE PROVIDER

INSTRUCTIONS to the HEALTH CARE PROVIDER: Your patient has requested leave under the FMLA. Answer, fully and completely, all applicable parts. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can; terms such as "lifetime," "unknown," or "indeterminate" may not be sufficient to determine FMLA coverage. Limit your responses 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, hospice, 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 year 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 in Section I 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 condition, 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 treatment 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 _____

7. Will the condition cause episodic flare-ups periodically preventing the employee from performing his/her job functions? ____No ____Yes.

   Is it medically necessary for the employee to be absent from work during the flare-ups? ____ No ____Yes. If so, explain:

   _____

   _____

   Based upon the patient's medical history and your knowledge of the medical condition, estimate the frequency of flare-ups and the duration of related incapacity that the patient may have over the next 6 months (e.g., 1 episode every 3 months lasting 1-2 days):

Frequency : _____ times per _____ week(s) _____ month(s)

Duration: _____ hours or ___ day(s) per episode

ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER.

_____

_____

_____

_____

_____

_____

Signature of Health Care Provider **Date**

PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT

If submitted, it is mandatory for employers to retain a copy of this disclosure in their records for three years. 29 U.S.C. § 2616; 29 C.F.R. § 825.500. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. The Department of Labor estimates that it will take an average of 20 minutes for respondents to complete this collection of information, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, U.S. Department of Labor, Room S-3502, 200 Constitution Ave., NW, Washington, DC 20210. **DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR; RETURN TO THE PATIENT.**

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

U.S. Department of Labor
Wage and Hour Division

OMB Control Number: 1235-0003
Expires: 2/28/2015

SECTION I: For Completion by the EMPLOYER

INSTRUCTIONS to the EMPLOYER: The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA 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 Section I before giving this form to your employee. Your response is voluntary. While you are not required to use this form, you may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. §§ 825.306-825.308. Employers must generally maintain records and documents relating to medical certifications, recertifications, or medical histories of employees' family members, created for FMLA purposes as confidential medical records in separate files/records from the usual personnel files and in accordance with 29 C.F.R. § 1630.14(c)(1), if the Americans with Disabilities Act applies.

Employer name and contact: _____

_____

SECTION II: For Completion by the EMPLOYEE

INSTRUCTIONS to the EMPLOYEE: Please complete Section II before giving this form to your family member or his/her medical provider. The FMLA permits an employer to require that you submit a timely, complete, and sufficient medical certification to support a request for FMLA leave to care for a covered family member with a serious health condition. If requested by your employer, your response is required to obtain or retain the benefit of FMLA protections. 29 U.S.C. §§ 2613, 2614(c)(3). Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA request. 29 C.F.R. § 825.313. Your employer must give you at least 15 calendar days to return this form to your employer. 29 C.F.R. § 825.305.

Your 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 Signature Date

CONTINUED ON NEXT PAGE

SECTION III: For Completion by the HEALTH CARE PROVIDER

INSTRUCTIONS to the HEALTH CARE PROVIDER: The employee listed above has requested leave under the FMLA to care for your patient. Answer, fully and completely, all applicable parts below. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can; terms such as "lifetime," "unknown," or "indeterminate" may not be sufficient to determine FMLA coverage. Limit your responses to the condition for which the patient needs leave. Page 3 provides space for additional information, should you need it. 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: _____

   Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility?
   ___No ___Yes. If so, dates of admission: _____

   Date(s) you treated the patient for condition: _____

   Was medication, other than over-the-counter medication, prescribed? ___No ___Yes.

   Will the patient need to have treatment visits at least twice per year 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: _____

3. Describe other relevant medical facts, if any, related to the condition for which the patient needs care (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment):

_____

_____

_____

_____

PART B: AMOUNT OF CARE NEEDED: When answering these questions, keep in mind that 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:

4. Will the patient be incapacitated for a single continuous period of time, including any time for treatment and recovery? ___No ___Yes.

   Estimate the beginning and ending dates for the period of incapacity: _____

   During this time, will the patient need care? __ No __ Yes.

   Explain the care needed by the patient and why such care is medically necessary:

   _____

   _____

   _____

   _____

   _____

5. Will the patient require follow-up treatments, including any time for recovery? ___No ___Yes.

   Estimate treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including any recovery period:

   _____

   Explain the care needed by the patient, and why such care is medically necessary: _____

   _____

6. Will the patient require care on an intermittent or reduced schedule basis, including any time for recovery? __ No __ Yes.

   Estimate the hours the patient needs care on an intermittent basis, if any:

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

   Explain the care needed by the patient, and why such care is medically necessary:

   _____

   _____

   _____

   _____

7. Will the condition cause episodic flare-ups periodically preventing the patient from participating in normal daily activities? ____No ____Yes.

   Based upon the patient's medical history and your knowledge of the medical condition, estimate the frequency of flare-ups and the duration of related incapacity that the patient may have over the next 6 months (e.g., 1 episode every 3 months lasting 1-2 days):

   Frequency: _____ times per _____ week(s) _____ month(s)

   Duration: _____ hours or ___ day(s) per episode

   Does the patient need care during these flare-ups? ____ No ____ Yes.

   Explain the care needed by the patient, and why such care is medically necessary: _____

_____

_____

_____

_____

ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER.

_____

_____

_____

_____

_____

_____

_____ _____

Signature of Health Care Provider **Date**

PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT

If submitted, it is mandatory for employers to retain a copy of this disclosure in their records for three years. 29 U.S.C. § 2616; 29 C.F.R. § 825.500. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. The Department of Labor estimates that it will take an average of 20 minutes for respondents to complete this collection of information, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, U.S. Department of Labor, Room S-3502, 200 Constitution Ave., NW, Washington, DC 20210.
DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR; RETURN TO THE PATIENT.

Designation Notice (Family and Medical Leave Act)

U.S. Department of Labor
Wage and Hour Division

U.S. Wage and Hour Division

OMB Control Number: 1235-0003
Expires: 2/28/2015

Leave covered under the Family and Medical Leave Act (FMLA) must be designated as FMLA-protected and the employer must inform the employee of the amount of leave that will be counted against the employee's FMLA leave entitlement. In order to determine whether leave is covered under the FMLA, the employer may request that the leave be supported by a certification. If the certification is incomplete or insufficient, the employer must state in writing what additional information is necessary to make the certification complete and sufficient. While use of this form by employers is optional, a fully completed Form WH-382 provides an easy method of providing employees with the written information required by 29 C.F.R. §§ 825.300(c), 825.301, and 825.305(c).

To: _____

Date: _____

We have reviewed your request for leave under the FMLA and any supporting documentation that you have provided. We received your most recent information on _____ and decided:

_____ **Your FMLA leave request is approved. All leave taken for this reason will be designated as FMLA leave.**

The FMLA requires that you notify us as soon as practicable if dates of scheduled leave change or are extended, or were initially unknown. Based on the information you have provided to date, we are providing the following information about the amount of time that will be counted against your leave entitlement:

_____ Provided there is no deviation from your anticipated leave schedule, the following number of hours, days, or weeks will be counted against your leave entitlement: _____

_____ Because the leave you will need will be unscheduled, it is not possible to provide the hours, days, or weeks that will be counted against your FMLA entitlement at this time. You have the right to request this information once in a 30-day period (if leave was taken in the 30-day period).

Please be advised (check if applicable):

_____ You have requested to use paid leave during your FMLA leave. Any paid leave taken for this reason will count against your FMLA leave entitlement.

_____ We are requiring you to substitute or use paid leave during your FMLA leave.

_____You will be required to present a fitness-for-duty certificate to be restored to employment. If such certification is not timely received, your return to work may be delayed until certification is provided. A list of the essential functions of your position ___ **is** ___ **is not** attached. If attached, the fitness-for-duty certification must address your ability to perform these functions.

_____ **Additional information is needed to determine if your FMLA leave request can be approved:**

_____ The certification you have provided is not complete and sufficient to determine whether the FMLA applies to your leave request. You must provide the following information no later than _____, unless it is not
(Provide at least seven calendar days)
practicable under the particular circumstances despite your diligent good faith efforts, or your leave may be denied.

_____
(Specify information needed to make the certification complete and sufficient)

_____

_____ We are exercising our right to have you obtain a second or third opinion medical certification at our expense, and we will provide further details at a later time.

_____ Your FMLA Leave request is Not Approved.
_____ The FMLA does not apply to your leave request.
_____ You have exhausted your FMLA leave entitlement in the applicable 12-month period.

PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT

It is mandatory for employers to inform employees in writing whether leave requested under the FMLA has been determined to be covered under the FMLA. 29 U.S.C. § 2617; 29 C.F.R. §§ 825.300(d), (e). It is mandatory for employers to retain a copy of this disclosure in their records for three years. 29 U.S.C. § 2616; 29 C.F.R. § 825.500. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. The Department of Labor estimates that it will take an average of 10 – 30 minutes for respondents to complete this collection of information, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, U.S. Department of Labor, Room S-3502, 200 Constitution Ave., NW, Washington, DC 20210. **DO NOT SEND THE COMPLETED FORM TO THE WAGE AND HOUR DIVISION.**

Policies
Section 04: Personnel

Policy 04:130
Family Medical Leave

In compliance with the Family and Medical Leave Act of 1993 (FMLA) and the National Defense Authorization Act, the University of Montevallo will grant an eligible employee up to 12 weeks of unpaid leave during any one-year period. The one-year period is based on a "rolling" 12-months, measured backward from the first day of any FMLA leave for which the employee qualifies.

Eligibility for Family or Medical Leave: Employees who have been employed by UM for at least 12 months (or 52 weeks) and who have worked at least 1250 hours during the preceding 12 months may take up to 12 weeks of unpaid leave during any 12-month period, measured backward from the first date an employee uses FMLA leave for the following reasons:

1) A serious health condition which renders the employee unable to perform the functions of his or her position;

2) To care for an employee's spouse, child, or parent who has a serious health condition; or

3) Birth or adoption of a child or placement of a child with the employee for foster care. Leave for this reason may be taken only during the first 12 months following the birth, adoption or placement of the child.

4) Any qualifying exigency arising out of the fact that the spouse, child, or parent of the employee is either on active duty or has been notified of an impending call or order to active duty in the Armed Forces in support of a contingency operation.

An employee who is the spouse, child, parent or next of kin of a covered service member may be entitled to 26 weeks of unpaid leave in a single 12-month period in order to care for the service members. During the single 12-month period in which leave is taken to care for a covered service member, if the employee needs FMLA leave for any other reason, the employee is entitled to a combined total of 26 weeks. The availability of leave for another reason in any other 12-month period shall not be limited.

A serious health condition of an in-law does not qualify under FMLA provisions. Any leave taken pursuant to this policy shall count toward the employee's 12-week FMLA leave total.

Leave for Serious Health Conditions, Qualifying Exigencies: Where FMLA leave is requested due to a serious health condition of the employee, spouse, child or parent, or to qualifying exigencies, or to care for an injured service member the leave may be taken intermittently or on a reduced-hour basis only if such an arrangement is necessary. If intermittent or reduced-hours leave is required, the University may, at its sole discretion, temporarily transfer the employee to

another position with equivalent pay and benefits if that job will better accommodate such leave. Requests for FMLA leave due to a serious health condition or the need to care for a covered service member must be supported by a certification from the health care provider, and the University reserves the right to require a second medical opinion at the University's expense. If the first and second opinions differ, the University may, at its own expense, require a third opinion from a health care provider jointly approved by the University and the employee; this third opinion shall be binding.

For purposes of FMLA leave, a "serious health condition" means an illness, injury, impairment or other physical or mental condition that involves: (1) a period of incapacity or treatment related to inpatient care in a hospital or other medical care facility; (2) a period of incapacity that involves continuing treatment by a health care provider and requires absence from regular daily activities such as work or school for more than three calendar days; or (3) continuing treatment by a health care provider for prenatal care or for a chronic or long-term health condition that is incurable or so serious that lack of treatment would likely result in incapacity for more than three calendar days. If the employee and employee's spouse are both employed by UM, their combined leave to care for a sick parent or for a qualifying exigency is limited to 12 weeks and their combined leave to care for an injured service member is limited to 26 weeks.

Leave for Birth, Adoption or Placement of Child: Where FMLA leave is requested for the birth, adoption or placement of a child, intermittent leave or working a reduced number of hours is only permitted when the University and the employee jointly agree. If both parents are employed by UM, their combined leave for the birth, adoption or placement of a child is limited to 12 weeks.

Requests for Leave: Requests for FMLA leave must be submitted in writing at least 30 calendar days before the leave is to commence, or if the event is not foreseeable, the leave must be requested as soon as practicable after the qualifying event. The request must include the anticipated timing and duration of the leave. FMLA leave may be delayed for failure to provide this required notice. FMLA Application forms are available on-line and in the Office of Human Resources.

Employees requesting leave for treatment of a serious health condition must make reasonable efforts to schedule the treatment so as to avoid disruption of the University's operations. Requests for FMLA leave due to a serious health condition must be supported by a certification from the health care provider. Failure to provide the required medical certification upon request may result in the denial of FMLA leave. Certification of Health Care Provider forms are available in the Office of Human Resources.

Completed requests for leave, as well as subsequent documentation related to leave must be submitted to the Office of Human Resources.

Contact During Leave: Employees on FMLA leave must contact the University every two weeks regarding their current status and intent to return to work, unless physically or mentally unable to do so due to the employee's own serious health condition. This contact may be by

telephone to the employee's Department Chair, Director, supervisor, or Director of Human Resources.

In addition, employees must promptly notify the University if: (1) they no longer intend to return to work at the expiration of FMLA leave, (2) they wish to return to work at the expiration of leave but may be unable to do so, (3) the circumstances described in the original certification have changed significantly, or (4) they desire an extension of leave (but not to exceed a total of 12 weeks). Such notification must be given in writing to employee's Department Chair, Director, or supervisor.

Use of Sick and Vacation Days and Substitution of other Paid Leave During FMLA Leave: If applicable, employees are required to use all their available vacation and compensatory time during any period of FMLA leave. Employees must also use available sick days when the FMLA leave is taken because of a serious health condition. The University will require that employees substitute any other paid leave for FMLA leave. When vacation days, sick days or compensatory time is used during an FMLA leave, they will be paid according to current University policies regarding such benefits.

Benefits During Leave: During unpaid FMLA Leave, employees do not accrue employment benefits such as vacation or sick leave. Those employees on intermittent or reduced-schedule leave accrue leave in proportion to the work performed. Employment benefits accrued by the employee prior to the commencement of FMLA leave will not be lost. For purposes of retirement vesting or eligibility, any period of FMLA leave will be treated as uninterrupted service.

During FMLA leave, the University will continue to pay its portion of the health insurance premiums for a covered employee and dependents, and the employee must continue to pay the employee's share of the premium. If the employee does not return to work following the FMLA leave, the employee must reimburse the University for any health insurance premiums paid by the University during leave, unless the employee's failure to return is due to a serious health condition which prevents the employee from performing his or her job, or because of other circumstances beyond the employee's control.

Employees who wish to continue their sponsored life insurance must also continue to pay the premiums for this coverage while on FMLA leave.

Payment for health and life insurance premiums must be received in the Office of Human Resources by the 5th day of each month. Failure to pay any required premium for 30 days will result in loss of coverage. Payment should be made payable to the University of Montevallo and mailed to:

University of Montevallo

Office of Human Resources

Station 6055

Montevallo, AL 35115

Return From Leave: An employee who returns to work from an FMLA leave on or before the first business day following the expiration of the leave is entitled to return to the same or an equivalent position, unless the employee's employment would otherwise have been terminated regardless of the employee's family or medical leave. However, where the FMLA leave was due to the employee's own serious health condition, the returning employee must provide written certification from the health care provider that the employee is able to resume the duties of the job.

Special Exception for Key Employees: When a key employee requests FMLA leave, the University reserves the right to deny reinstatement if reinstatement of that employee would cause substantial and grievous economic injury to the operation of the University. For purposes of FMLA leave, a "key employee" is a salaried employee who is eligible for family or medical leave and is among the highest paid ten percent of all employees employed by the University within 75 miles of the employee's worksite. Key employees will be notified in writing of their status as key employees at the time they request FMLA leave. If the University determines that reinstatement of a key employee would result in substantial and grievous economic injury to the operation of the University, the University will promptly notify the key employee in writing.

Limitations on Leave: Use of FMLA leave for purposes other than as set forth by the FMLA is strictly prohibited and may result in disciplinary action, up to and including termination. The University's policy relating to outside employment (See Policy 04:001) continues to apply to employees while on FMLA leave.

This policy does not create any employment rights for any individual other than those specifically stated in the policy. The University is sole administrator of this policy and, as such, is the exclusive interpreter of its terms. All provisions of this policy shall be interpreted consistent with the Family and Medical Leave Act of 1993. The University reserves the right to impose any limitations or conditions upon any leave of absence as may be deemed consistent with the provisions of the Act. Any questions concerning this policy may be directed to the Office of Human Resources.

Approved 5/96

Last Revised 8/08