**FAMILY AND MEDICAL LEAVE POLICY**

**PURPOSE**

[EMPLOYER'S NAME] offers unpaid, job-protected leave as required by the Family and Medical Leave Act of 1993 (FMLA), which provides eligible employees with leave for certain qualifying situations.

To be eligible for FMLA leave, employees must:

1. Have been employed by [EMPLOYER'S NAME] for at least 12 months (non-consecutive employment counts).
2. Have worked at least 1,250 hours in the preceding 12 months.
3. Be employed at a location with 50 or more employees within a 75-mile radius.

For questions about FMLA eligibility, contact the [HUMAN RESOURCES DEPARTMENT].

**FAMILY AND MEDICAL LEAVE**

Eligible employees may take up to 12 or 26 weeks of family or medical leave [(or up to 72 or 156 days for eligible airline flight crew employees)], depending on the circumstances outlined below, within the applicable 12-month period.

During FMLA leave, [EMPLOYER'S NAME] will continue your group health insurance coverage under the same terms and conditions as if you were actively working.

Upon returning from approved FMLA leave, you are entitled to reinstatement to your original job or an equivalent position, subject to applicable laws and any exceptions outlined therein.

**LEAVE ENTITLEMENT**

Eligible employees are entitled to the following unpaid FMLA leave within a designated 12-month period:

12 weeks of leave

You may take up to 12 weeks [(or 72 days, if you are an eligible airline flight crew employee)] of unpaid leave within a 12-month period, which is [calculated as a calendar year/a fiscal year/measured from your hire anniversary/measured forward from the first FMLA leave date/using a "rolling" backward method], for the following reasons:

* Childbirth and care: To care for a newborn child, provided the leave is completed within one year of birth.
* Adoption or foster placement: To care for a newly adopted or fostered child, provided the leave is completed within one year of placement.
* Family care: To care for a spouse, child, or parent with a serious health condition.
* Employee's own health: If you have a serious health condition that makes you unable to perform the essential duties of your job.
* Military exigency: For qualifying exigencies related to a spouse, child, or parent who is a military member on covered active duty, called to covered active duty, or notified of impending active duty.

26 weeks of leave

You may take up to 26 weeks [(or 156 days, if you are an eligible airline flight crew employee)] of unpaid leave in a single 12-month period. This leave, known as military caregiver leave, is for the care of a spouse, child, parent, or next of kin who is a covered service member with a serious illness or injury sustained during active duty, as defined by FMLA regulations.

**FMLA LEAVE FOR SPOUSES EMPLOYED BY [EMPLOYER'S NAME]**

If both spouses are employed by [EMPLOYER'S NAME] and are eligible for FMLA leave, the following limitations may apply:

Combined 12 weeks of leave

Spouses may take a combined total of 12 weeks of FMLA leave within the same 12-month period for:

* The birth of a child and care for that child.
* The placement of a child for adoption or foster care and care for the newly placed child.
* Caring for a parent with a serious health condition.

Combined 26 weeks of leave

Spouses may take a combined total of 26 weeks of FMLA leave in a single 12-month period if the leave is for:

* Military caregiver leave.
* A combination of military caregiver leave and other FMLA-qualifying reasons.

**NOTICE OF LEAVE**

If your need for FMLA leave is foreseeable, you are required to provide [EMPLOYER'S NAME] with at least 30 days’ advance written notice. If 30 days’ notice is not possible, you must notify [EMPLOYER'S NAME] as soon as practicable, typically within one to two business days of becoming aware of your need for leave. Failure to provide timely notice may result in a delay of FMLA-protected leave, subject to the specific circumstances.

For planned medical treatments, a series of treatments, or military caregiver leave, you must consult with [EMPLOYER'S NAME] beforehand to coordinate the scheduling of leave to minimize disruption to the workplace while accommodating your needs or those of the covered military member.

If the need for leave is unforeseeable, you are expected to inform [EMPLOYER'S NAME] within one to two business days of becoming aware of the need for leave, except in extraordinary situations.

Family and Medical Leave Act request forms are available from the [HUMAN RESOURCES DEPARTMENT]. When requesting leave, you are required to submit a written request using this form.

**CERTIFICATION OF NEED FOR LEAVE**

If you are requesting leave for your own or a covered relative’s serious health condition, you and the relevant health care provider must provide appropriate medical certification. Medical certification forms are available from the [HUMAN RESOURCES DEPARTMENT]. When leave is requested, [EMPLOYER'S NAME] will inform you if medical certification is required and specify the due date, which will be at least 15 days from the date of your leave request. If you give at least 30 days’ notice for medical leave, the medical certification should be submitted before the leave begins. Failure to provide timely certification may result in a delay or denial of FMLA-protected leave.

[EMPLOYER'S NAME] reserves the right, at its expense, to require an evaluation by a second health care provider designated by [EMPLOYER'S NAME]. If the second opinion conflicts with the initial certification, [EMPLOYER'S NAME] may, at its expense, require a third health care provider, mutually agreed upon, to conduct an evaluation. The third opinion will be final and binding. Recertification may also be required periodically, and failure to provide requested certification within 15 days, when practicable, may result in further leave being delayed.

For military caregiver leave, [EMPLOYER'S NAME] may require certification from the covered military member’s health care provider. Certification may also be required for leave related to a military exigency.

**COMMUNICATION DURING LEAVE**

Employees taking leave for their own serious health condition or to care for a covered relative must regularly update [EMPLOYER'S NAME] on [REQUIRED FREQUENCY] about the status of the condition and their plans for returning to work.

If the duration of your leave changes, is extended, or was initially unknown, you must notify [EMPLOYER'S NAME] as soon as practicable, typically within two business days, if feasible.

**UNPAID LEAVE POLICY**

FMLA leave is unpaid; however, you [may/will be required to] substitute accrued and unused [vacation/paid time off/sick days/personal days] as follows:

* Parental leave: If leave is requested for the birth, adoption, or foster care placement of a child, any accrued and unused paid leave [will/may] first be applied to unpaid FMLA leave and run concurrently.
* Personal or family care: If leave is requested for your own serious health condition or to care for a covered relative with a serious health condition, any accrued paid [vacation/personal/family or medical/sick] leave [will/may] be applied to unpaid FMLA leave and run concurrently.

The substitution of paid leave for unpaid FMLA leave does not extend the total leave entitlement of 12 or 26 weeks, as applicable. In no instance will the substitution of paid leave result in receiving more than 100% of your regular salary.

FMLA leave runs concurrently with other leave types, such as accrued vacation leave or state family leave, to the extent permitted by state law.

**MEDICAL AND OTHER BENEFITS**

During approved FMLA leave, [EMPLOYER'S NAME] will maintain your health benefits as if you were actively employed.

* Paid leave: If paid leave is substituted for unpaid FMLA leave, your portion of the health plan premium will continue to be deducted as a regular payroll deduction.
* Unpaid leave: If your leave is unpaid, you are responsible for paying your portion of the premium through [PAYMENT METHOD]. Health coverage will be terminated if your payment is more than 30 days late. If a payment is more than 15 days late, [EMPLOYER'S NAME] will notify you in writing. If the premium is not received within 15 days of the notice, your coverage may be discontinued.

If you do not return to work for at least 30 calendar days following your leave, you may be required to reimburse [EMPLOYER'S NAME] for health plan premiums paid on your behalf during the unpaid leave period. Exceptions will be made if you are unable to return due to a serious health condition or circumstances beyond your control.

**INTERMITTENT AND REDUCED LEAVE SCHEDULE**

FMLA leave may be taken intermittently (in separate blocks of time) or on a reduced leave schedule (with fewer hours per workweek or workday) in the following circumstances:

* When medically necessary due to your own or a covered relative’s serious health condition.
* For a qualifying exigency related to covered military service.

If the leave is unpaid, [EMPLOYER'S NAME] will adjust your salary based on the hours or days you actually work. Additionally, while you are on an intermittent or reduced leave schedule, [EMPLOYER'S NAME] may temporarily transfer you to an alternative position that better accommodates your schedule, provided the position offers equivalent pay and benefits.

**RETURNING FROM LEAVE**

If you take leave for your own serious health condition (excluding intermittent leave), you must provide medical certification confirming your fitness to return to work. This requirement applies to all employees returning from medical leave. You will not be allowed to resume your duties until the certification is submitted.

**COORDINATION WITH STATE OR LOCAL FAMILY AND MEDICAL LEAVE LAWS**

When state or local family and medical leave laws provide greater protections or benefits than those offered under this policy, the more favorable provisions of the applicable laws will take precedence.

**APPLICABILITY TO COLLECTIVE BARGAINING AGREEMENTS**

The terms of this policy operate alongside, but do not replace, modify, or supplement, any conditions outlined in a collective bargaining agreement (CBA) between a union and [EMPLOYER'S NAME].

Employees should review their collective bargaining agreement for clarification. In cases where this policy conflicts with the terms in the CBA, the provisions of the CBA will prevail.

This policy complies with all applicable laws and regulations in the state of Iowa.

**ACKNOWLEDGEMENT OF RECEIPT AND REVIEW**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (employee name), acknowledge that on \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (date), I received and reviewed a copy of [EMPLOYER'S NAME]’s [NAME OF POLICY]. I understand that it is my responsibility to familiarize myself with the policy and adhere to its terms.

I also acknowledge that this policy is not intended to create an employment contract or alter my at-will employment status, unless otherwise specified in a written agreement signed by an authorized representative of [EMPLOYER'S NAME]. Any delay or failure by [EMPLOYER'S NAME] to enforce the provisions of this policy does not constitute a waiver of its rights to enforce them in the future.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date