TEAM MEMBER NOTIFICATION OF REQUIREMENTS FOR ELIGIBILITY FOR FMLA BENEFITS

Team Member Name _____ **Team Member ID** _____
Last, First, Middle Initial (Please Print)

If you have worked for Carolinas HealthCare System for more than 12 months and worked at least 1,250 hours in the last 12 months, you may be eligible for benefits under the Family Medical Leave Act (FMLA). This benefit provides job and benefit protection for continuous or intermittent absences needed for one of the following reasons.

- A team member's serious medical condition;

  or
- A team member's need to care for a spouse, parent, or child (under the age of 18, or with a disability that makes that child dependent on the parent) with a serious medical condition;

  or
- To care for the team member's newborn child, the team member's newly adopted child, or a child recently placed in the team member's home for foster care.

You may apply for this benefit by completing either a *Request for Medical Leave* or a *Request for Family Care Leave*. The policies about this benefit and how to apply for it are found in the Human Resources Policy and Procedure Manual (located under Human Resources on PeopleConnect). You should apply for this benefit no more than thirty days prior to the first day of absence. If an unplanned leave becomes necessary, you must complete the application process as soon as possible, but always within fifteen days from the first day of your leave.

A team member who fraudulently obtains FMLA Leave from CHS is not protected by the Family and Medical Leave Act's job restoration or maintenance of health benefits provisions and will be subject to appropriate disciplinary action up to, and including, discharge. Similarly, a team member who fraudulently obtains discretionary leave or other medical leave under this policy will be subject to appropriate disciplinary action up to, and including, discharge.

If you have any questions regarding this benefit, please contact your Department Leader or Leave of Absence Administration at (704) 631-0262.

If you currently have an approved Leave of Absence or ADA Accommodation, please check one of the following:

☐ Apply this absence to my Leave of Absence. ☐ Apply this absence to my ADA.

Date of Absence: _____/_____/_____

Number of FMLA or ADA hours applied to this absence: _____

Number of PTO hours applied to this absence (Use of PTO is optional): _____

Type of Leave:

☐ Medical Leave of Absence

☐ Family Care Leave of Absence: ☐ Child ☐ Spouse ☐ Parent

☐ This absence is not related to my current approved Leave of Absence.

_____ _____

Team Member Signature **Date**