

EMERGENCY FAMILY AND MEDICAL LEAVE REQUEST FORM PURSUANT TO THE FAMILIES FIRST CORONAVIRUS ACT

EMPLOYEES WHO ARE UNABLE TO WORK (OR TELEWORK) FOR A REASON THAT QUALIFIES FOR EMERGENCY FMLA (EFMLA) PURSUANT TO THE FAMILIES FIRST CORONAVIRUS RESPONSE ACT (FFCRA) MUST COMPLETE THIS FORM. YOU MUST PROVIDE AS MUCH ADVANCE NOTICE AS IS REASONABLY PRACTICABLE.

UPON COMPLETION OF THIS FORM, SUBMIT TO _____ FOR REVIEW, APPROVAL AND PROCESSING.

EMPLOYEE NAME: _____ PHONE NUMBER: _____

EMPLOYEE HOME ADDRESS: _____ E-MAIL: _____

ANTICIPATED START DATE OF LEAVE: _____ EXPECTED END DATE OF LEAVE: _____

REASON FOR LEAVE (CHECK ALL APPLICABLE): I AM UNABLE TO WORK (OR TELEWORK) FOR THE FOLLOWING REASON(S):

I NEED TO CARE FOR MY SON OR DAUGHTER UNDER THE AGE OF 18 BECAUSE MY CHILD'S ELEMENTARY OR SECONDARY SCHOOL HAS BEEN CLOSED DUE TO A PUBLIC HEALTH EMERGENCY", AS DEFINED BY THE FFCRA

I NEED TO CARE FOR MY SON OR DAUGHTER UNDER AGE 18 BECAUSE MY CHILD'S PLACE OF CARE HAS BEEN CLOSED DUE TO A "PUBLIC HEALTH EMERGENCY".

I NEED TO CARE FOR MY SON OR DAUGHTER UNDER AGE 18 BECAUSE THE CHILD CARE PROVIDER FOR MY SON OR DAUGHTER IS UNAVAILABLE BECAUSE OF A "PUBLIC HEALTH EMERGENCY".

I NEED TO CARE FOR MY CHILD UNDER AGE 18 BECAUSE THE CHILD'S SCHOOL, CHILD CARE OR CHILD CARE PROVIDER IS CLOSED OR UNAVAILABLE BECAUSE OF COVID-19

NAME OF MINOR CHILD(REN) AND NAME(S) AND ADDRESS(ES) OF MINOR CHILD(REN)'S SCHOOL, CHILD CARE OR CHILD CARE PROVIDER(S):

MINOR CHILDREN: _____

SCHOOL AND/OR CHILD CARE PROVIDER(S): _____

PROVIDE ANY SUPPORTING DOCUMENTATION RELATED TO YOUR NEED FOR EFMLA. FOR EXAMPLE, PLEASE PROVIDE NOTICE OF THE SCHOOL OR CHILD CARE CLOSURE POSTED ON A GOVERNMENT, SCHOOL, OR DAY CARE WEBSITE, PUBLISHED IN A NEWSPAPER, OR E-MAILED TO YOU FROM AN EMPLOYEE OR OFFICIAL OR THE SCHOOL, CHILD CARE FACILITY OR PROVIDER.

I WILL NEED (CHOOSE ONE): CONTINUOUS LEAVE: INTERMITTENT LEAVE: _____

IF YOUR NEED FOR LEAVE IS INTERMITTENT, PLEASE DESCRIBE THE NATURE OF YOUR INTERMITTENT LEAVE:

IF TELEWORKING, INTERMITTENT LEAVE IS NOT GUARANTEED AND WILL BE EVALUATED BASED UPON BUSINESS NEEDS.

SUBSTITUTION OF PAID LEAVE: PURSUANT THE FFCRA, THE FIRST 10 DAYS OF YOUR LEAVE IS UNPAID, HOWEVER YOU MAY BE ELIGIBLE FOR EMERGENCY SICK LEAVE PROVIDED THROUGH FFCRA. IN THE EVENT YOU ARE NOT ELIGIBLE FOR EMERGENCY SICK LEAVE, YOU ARE PERMITTED TO USE OTHER AVAILABLE PAID TIME OFF TO COVER THIS PERIOD. PLEASE INDICATE IF YOU WOULD LIKE TO USE OTHER PAID TIME OFF BENEFITS (SICK, VAC, PTO) DURING THE FIRST 10 DAYS OF YOUR ABSENCE (IF YOU ARE NOT ELIGIBLE FOR EMERGENCY SICK LEAVE) AND HOW MANY HOURS YOU PLAN TO USE.

I CERTIFY THAT THE ABOVE INFORMATION IS ACCURATE AND COMPLETE. I UNDERSTAND THAT IF THE CIRCUMSTANCES OF MY LEAVE CHANGE, AND I AM ABLE TO RETURN TO WORK EARLIER THAN THE DATE INDICATED ON THIS FORM, I AM REQUIRED TO NOTIFY MY EMPLOYER.

EMPLOYEE SIGNATURE: _____

DATE: _____

FOR HUMAN RESOURCES' INTERNAL USE ONLY: RECEIVED BY: _____ DATE: _____