

EMPLOYEE REQUEST FOR EMERGENCY FAMILY AND MEDICAL LEAVE

This form is to be completed by employees who are requesting Emergency FMLA (EFMLA) pursuant to the Families First Coronavirus Response Act (FFCRA). You must provide as much advance notice as reasonably possible. Please submit completed forms to your **[Human Resources Department, Practice Manager, or Owner]** for processing.

Employee Name:	
Employee Home Address:	
Email:	
Home Phone:	Cell Phone:
This is a (circle one): New request for leave	Request for an extension of leave
Anticipated Begin Date of Leave:	Expected Return to Work Date:
Reason for Leave (check all applicable) I am unable to work (or telework) for the following reasons: <ul style="list-style-type: none"> <input type="checkbox"/> I need to care for my son or daughter under age 18 because my child's elementary or secondary school has been closed due to a public health emergency. <input type="checkbox"/> 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. <input type="checkbox"/> 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 will need (circle one): Continuous leave Intermittent leave	
If your need for leave is intermittent, please describe the nature of your intermittent leave:	

Substitution of Paid Leave: Pursuant to the FFCRA, the first 10 days of your leave is unpaid, however you may be eligible for emergency sick leave provided through the FFCRA. In the event you are not eligible for emergency sick leave, you are permitted to use available paid leave to cover this period. Please indicate if you would like us to use paid leave 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.	
Vacation (____Hrs)	Sick Leave (____Hrs)
Personal (____Hrs)	Other (____Hrs)

I certify that the above information is accurate and complete. I understand that if I fail to report to work on or before the scheduled return date indicated above or fail to contact [Human Resources, Practice Manager, Owner] regarding my absence from work beyond such scheduled date of return, my employer may take corrective action.

Employee Signature: _____

Date: _____

Human Resources Signature

Date