DESIGNATION NOTICE FOR
EMERGENCY FAMILY AND MEDICAL LEAVE EXPANSION ACT

To: _____ (Employee Name)

From: _____ (Administrator)

Company Name: _____

Date: _____

We have reviewed your request for leave under the Emergency Family and Medical Leave Expansion Act (EFMLA) and any supporting documentation that you have provided. We received your most recent information _____ (Date) and have decided:

I. Leave Approved:

☐ Your EFMLA request is approved. The leave you are taking for the following reasons will be designated as leave under the EFMLA and the Family and Medical Leave Act (FMLA), if applicable:

- ☐ I am subject to a federal, state, or local quarantine, isolation, containment, shelter-in-place, or stay-at-home order (collectively "Order"), related to COVID-19; or
- ☐ I have been advised by a health care provider to self-quarantine based on the provider's belief that I have, or may have, COVID-19, or I am particularly vulnerable to COVID-19; or
- ☐ I am experiencing symptoms of fever, dry cough, shortness of breath, or another COVID-19 symptom identified by the U.S. Centers for Disease Control and Prevention; or
- ☐ I am seeking or awaiting the results of a COVID-19 diagnosis/test; or
- ☐ I am obtaining a COVID-19 immunization; or
- ☐ I am caring for an individual who is subject to a federal, state, or local Order related to COVID-19 or who has been advised by a health care provider to self-quarantine based on the provider's belief that the individual has, or may have COVID-19, or is particularly vulnerable to COVID-19; or
- ☐ I must care for my child whose school or place of care is closed for reasons related to COVID-19; or
- ☐ I must care for my child whose child care provider is unavailable for reasons related to COVID-19.

You must notify us as soon as practicable if dates of scheduled leave change or need to be extended. 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 change to your work schedule and/or deviation from your anticipated leave schedule, the following number of hours, days or weeks will be counted against your leave entitlement:

_____**(HOURS/DAYS/WEEKS)**

Please be advised:

☐ You have requested to use EPSL during your leave. The requested and available EPSL time will be applied toward time taken off by you in the first ten (10) days of any EFMLA taken.

☐ You have requested to use other available paid time off benefits during your EFMLA. Any requested and available paid time off benefits will be applied toward time taken off by you during your EFMLA and will not extend the EFMLA time you may take.

II. Additional Information Is Needed:

☐ Additional information is needed to determine if your leave request can be approved

- ☐ The documentation you have provided does not sufficiently determine whether EFMLA applies to your leave request. You must provide the following information no later than 7 calendar days after receipt of this notice, unless it is not practicable under the particular circumstances despite your diligent, good faith efforts, or your leave may be denied. The following information is needed:

_____

_____

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III. Leave is NOT Approved:

☐ Your EFMLA Leave request is NOT APPROVED.

- ☐ The EFMLA does not apply to your leave request.
- ☐ You have exhausted all of your EFMLA/FMLA (if applicable) leave entitlement in the applicable 12-month period.
- ☐ Due to the Company's size, the Company has determined that providing you with leave would jeopardize the Company's viability as a going business concern.

Additional Information to the Employee:

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For any questions pertaining to your request for leave of absence, your leave of absence rights or responsibilities, and/or reinstatement, please refer to the Emergency Family and Medical Leave Expansion Act policy and Family and Medical Leave Act (if applicable) policy and/or please call your Human Resources Representative or designated individual.