EMERGENCY FAMILY AND MEDICAL LEAVE EXPANSION ACT
LEAVE REQUEST & NOTICE FORM

Employee Name:_____Employee Phone Number: _____

Employee Email Address: _____

Client Name:_____Client ID: _____

Date of Request:_____Manager/Supervisor: _____

Eligibility:

Have worked with company for 30 calendar days

Reason for Leave:

I am requesting Emergency Family and Medical Leave (EFML) because I am unable to work (including by means of telework) for the following reason(s):

☐ 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.

☐ 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.

☐ 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.

☐ I am seeking or awaiting the results of a COVID-19 diagnosis/test.

☐ I am obtaining a COVID-19 Immunization.

Date of First Immunization: _____

Date of Second Immunization: _____

☐ 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.

Name of individual and relation to myself:

_____

☐ Care for my child because my child's school or place of care is closed due to COVID-19.

☐ Care for my child because my child's care provider is unavailable due to COVID-19.

Name(s) of Child(ren):_____

_____

Child/Children's Current Age(s) and Date(s) of Birth:_____

_____

Name of Unavailable School(s), Place(s) of Care, or Child Care Provider(s):

_____

_____

_____

Are you the only suitable person who will be providing care for the child(ren) listed above during theperiod for which you are requesting EFMLA for this reason? ☐ YES ☐ NO

Will you be caring for a child who is age 15 or older during daylight hours, do special circumstances exist requiring you to provide care to that child? ☐ YES ☐ NO

Duration of Leave:

I request permission to take days off from work: _____through _____

OR,
to be absent on an intermittent or reduced schedule: _____through _____

If you are requesting to take child care leave on an intermittent or reduced schedule, please describe the proposed, requested schedule and explain why it is needed. (For example, reducing a 5-day workweek to working Mondays, Wednesdays, and Fridays, etc.). **Please note that requests to take EFMLA on an intermittent or reduced schedule are subject to Company approval.**

_____

_____

_____

Certification:

You will need to **submit documentation supporting your need for EFMLA** to **Human Resources** within fifteen (15) calendar days of your receipt of a Notice of Eligibility and Rights & Responsibilities. Appropriate documentation may include, for example, a notice posted on a government website, school or day care website or published in a newspaper; or an email from a school, day care or child care provider.

Use of Paid Time Off Benefits:

EFMLA is available for up to 12 total weeks (between April 1, 2020 and December 31, 2020). As of March 11, 2021, your employer has the right to choose whether or not to extend this EFMLA coverage to allow time to be taken through September 30, 2021. This extended time does NOT add any additional leave and the amount of EFMLA and FMLA granted is still limited to 12 weeks. Please reach out to your Corporate HR Team to determine your company's policy. Please see the EFMLA policy for more details. The first ten (10) days of EFMLA are unpaid unless you elect to use any accrued company provided, state, or local accrued vacation, PTO, paid personal leave, or other paid sick leave to supplement your Emergency Paid Sick Leave ("EPSL") during the first ten (10) days of EFMLA. In the chart below, please indicate if and how you want to use any accrued paid time off.

Full time employees may submit up to 80 hours or 10 days of paid time off while part time employees may submit hours based on their normal work schedule. It is not to exceed normal number of hours worked.

Type of Paid Time Off Benefit	**How Much Benefit to Use, If Available** (leave blank if you do not wish to use)	**Order of Use, if Available** (1st, 2nd, etc.; leave blank if you do not wish to use)

NOTE: If you choose multiple types of paid time off benefits, but do not indicate the sequence in which you want those benefits to be used, the Company has the discretion to decide.

Your employer may offer the option to "top off" or supplement your EFMLA partial income to get to 100% of your normal base salary/hourly rate. Please reach out to your manager for your company's specific practices.

NOTE: If you choose multiple types of paid time off benefits, but do not indicate the sequence in which you want those benefits to be used, the Company has the discretion to decide.

By submitting this form with the information provided by the employee, the employee acknowledges the information provided by the employee is true and complete. The employee understands that any incorrect, incomplete, or false statements furnished by the employee may result in sufficient cause for denial of leave and/or disciplinary action. The employee agrees to provide the employer with any documentation requested to validate the reasons for leave. The employee also grants permission for the employer to verify information furnished by the employee regarding leave. The employee acknowledges that they have read and understood the information contained in this document, and agrees to comply with the employer's policies and procedures related to EFMLA, as well as any other applicable policies and rules related to this leave request.

Employee Signature:_____ Date of Signature: _____

Manager Signature:_____ Date of Signature: _____

Please submit this request form to the Human Resources Representative or designated individual.