EMERGENCY FAMILY & MEDICAL LEAVE REQUEST (EFMLA)

Employees requesting 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 it to HR@Employerflexible.com for processing.

Employee Name:	**Company Name:**
Employee Home Address:	**E-mail:**
Home Phone Number:	**Cell Phone Number:**
Anticipated Begin Date of Leave:	**Expected Return to Work Date:**

Reason for Leave: I certify I am unable to work (or telework) for the following reason(s):

☐ I need to care for my son or daughter under age 18 whose school or place of care has been closed (or childcare provider is unavailable) due to a public health emergency with respect to COVID-19.

I will need *(choose one)*: ☐ Continuous leave ☐ Intermittent leave

If your need for leave is intermittent, please describe the nature of your intermittent leave:

☐ **I have attached documentation to support my request for EFMLA to this form** *(school closure announcement, etc.)*

☐ **I have not attached documentation to support my request for EFMLA to this form**

☐ **I understand that I will be responsible for any health benefit deductions and understand they will be deducted per pay period. I understand that the full details of the Emergency Paid Sick Leave can be found at https://www.dol.gov/agencies/whd/pandemic/ffcra-employee-paid-leave**

☐ **Pursuant to the FFCRA, the first two weeks of EFML is unpaid (80 hours for full-time). Please indicate how you would like to handle:**

☐ Available PTO/Sick/Vacation

☐ Unpaid leave

☐ Approved FFCRA Emergency Paid Sick Leave *(in this case, please submit an EPSL Request Form)*

☐ **I certify that my employer has stated that I am unable to telework.**

Employee Initials

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

Employee Signature *(or Designated Company Representative)*: _____

Date: _____