**EMERGENCY REQUEST FOR EMERGENCY FAMILY AND MEDICAL LEAVE**

Employees requesting Emergency Family and Medical Leave (EFML) pursuant to the Families First Coronavirus Response Act (FFCRA) must complete this form. You must provide as much advance notice as is practicable. Upon completion of this form, submit it to **[Insert appropriate individual or department]** for processing.

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| **Employee Name**:      |
| **Employee Home Address**:      **E-mail**:      |
| **Home Phone Number**:      **Cell Phone Number**:      |
| **This is a** *(choose 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: [ ]  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[ ]  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. Please submit the following: * The name and age of the child (or children) to be cared for:
* The name of the school that has closed or place of care that is unavailable:

If the child (or children) is older than fourteen, and you are unable to work or telework because of a need to care for them during daylight hours, please state any special circumstances that exist which require you to provide care.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **I will need** *(choose one)***:** [ ]  Continuous leave [ ]  Intermittent leaveIf 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 to use available paid leave during the first 10 days of your absence) and how many hours you plan to use.* [ ]  Vacation/PTO (      Hrs) [ ]  Sick Leave (      Hrs) [ ]  Personal (      Hrs) [ ] Other (      Hrs) |

**I certify that the above information is accurate and complete. I further certify that no other person will be providing care for the child (or children) during the period for which I am receiving Emergency Family and Medical Leave. I understand that if I fail to report for work on or before the scheduled return date indicated above or fail to contact [Insert appropriate individual or department] regarding my absence from work beyond such scheduled date of return, my employer may take corrective action.**

**Employee Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_