Insert Company Logo

REQUEST FOR FAMILY AND MEDICAL LEAVE ACT (FMLA) AND FAMILIES FIRST CORONAVIRUS RESPONSE ACT (FFCRA) LEAVE OF ABSENCE

Name:	**Date:**
Job Title:	
Date of Hire:	
Email Address:	
Address:	
Telephone:	

I request leave:

_____ For the birth or adoption of a child or for the placement of a child for foster care (certificate required)

_____ To care for an immediate family member (circle one: spouse child parent) with one of the following serious health conditions (certificate required):

_____

_____ Because I am unable to work due to one of the following serious health conditions (certificate required):

- a period of incapacity or treatment connected with inpatient care in a hospital, hospice, or residential medical care facility;
- a period of incapacity requiring absence of more than 3 calendar days from work, school, or other regular daily activities that also involves continuing treatment by (or under the supervision of) a health care provider;
- continuing treatment by (or under the supervision of) a health care provider for a chronic or long-term health condition that is incurable or so serious that, if not treated, would likely result in a period of incapacity of more than three calendar days or for pre-natal care;
- a permanent or long-term condition for which treatment may not be effective, which is being supervised by a health care provider.

_____ *Families First Coronavirus Response Act (FFCRA):* I am unable to work (including remote work) because I have to care for a son or daughter, under the age of 18, due to the child's school or child care provider being closed or unavailable due to a public health emergency (e.g., COVID-19 related closure/unavailability).

Please provide specifics regarding the reason for leave:

When FMLA Leave is needed to care for a seriously ill family member, the employee shall state the care he or she will provide and an estimate of the time period during which this care will be provided:

Length of leave requested: From _____/_____/_____ to _____/_____/_____
(Date) (Date)

When FMLA/FFCRA Leave is requested on a reduced or intermittent basis, the requester shall provide the desired schedule here:

I understand the following terms apply to my FMLA Leave of Absence:

- When the requested leave is for birth or placement for adoption or foster care placement of a child, it must conclude within 12 months of the birth or placement.
- Reduced or intermittent leave schedules for a serious health condition must be medically necessary and must be coordinated with the healthcare provider to least disrupt the Company's operations.
- The leave is unpaid, although I must use any accrued Earned Time Off (ETO) and exhaust other accrued, paid leave time.

I understand the following terms apply to my FFCRA Leave of Absence:

- Under this expanded event, employees out on FFCRA leave are entitled to compensation. The first 10 days of the leave is unpaid leave but employees may opt to use any accrued, unused paid time off, vacation time, sick leave, or other paid leave, or emergency paid sick leave provided under the FFCRA. After which, the employer must pay at least 2/3 of an employee's regular pay rate, capped at $200 per day, $10,000 in aggregate.
- This law applies to employers under 500 employees, as opposed to the 50-employee threshold for standard FMLA. Additionally, the definition of eligible employee is expanded to include those after only just 30 calendars days of hire.

If I do not return from FMLA/FFCRA Leave, the Company may require me to refund premiums paid for maintaining my and any eligible dependents' healthcare coverage during FMLA/FFCRA leave.

Upon my return I will be restored to my original job or to an equivalent job with equivalent pay, benefits, and other employment terms and conditions of employment, absent any applicable exception provided under the law. I will not be entitled to any more rights, benefits, or employment beyond that to which I would have been entitled had I not taken FMLA/FFCRA Leave.

I understand that I must request a leave of absence as far in advance as reasonably and practically possible. I must give 30 days' notice of my need to use FMLA Leave when the need is foreseeable. I understand that I will be required to provide medical certification to support my need for leave due to a serious health condition affecting an immediate family member or me. I also understand that the Company may require second and third medical opinions at the Company's expense, and periodic reports during FMLA Leave regarding my status and intent to return to work.

I understand that if FMLA Leave is needed to care for my immediate family member or for my own illness, and is for planned medical treatment, I must schedule treatment so that it will not unduly disrupt the Company's operations.

I understand that if FFCRA Leave is needed I will be required to provide documentation sufficient to support my need for leave to care for a minor son or daughter because their school or child care provider is closed or unavailable due to a public health emergency.

If I do not return to work at the expiration of my FMLA/FFCRA Leave, unless otherwise certified disabled, the Company will consider me to have resigned from my employment. If my failure to return to work is voluntary, I will be required to reimburse the Company for its share of the health insurance premiums paid on my behalf during my leave. By signing below, I agree that any such outstanding balance may be deducted from final monies owed to me by the Company and that I will repay any outstanding balance). If, however, I fail to return from such leave due to a serious health condition or for other similar circumstances beyond my control, I will not be required to reimburse the Company for its share of the health insurance premiums paid on my behalf.

I hereby verify that I understand and agree to the terms of the FMLA/FFCRA Policy.

_____ _____/____/_____

Employee's Signature Date