CULLMAN COUNTY COMMISSION

EMPLOYEE REQUEST FOR EMERGENCY FAMILY AND MEDICAL LEAVE

Employees requesting Emergency FMLA (FML EXP) pursuant to the Families First Coronavirus Response Act (FFCRA) must complete this form. **To be used for reasons unique to Emergency FMLA and for any time off beyond the 10 day (80 hours) maximum provided for in Emergency Paid Sick Leave.** You must provide as much advance notice as is reasonably practicable. Upon completion of this form, submit it to Human Resources for processing.

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 Taken From April 1, 2021 thru September 30, 2021 (*check all applicable*) I am unable to work (or telework) for the following reasons:

☐ (1) I am quarantined or isolated subject to a federal, state or local oder related to COVID-19 (FML EXP)
Name of the government entity issuing the order: _____

☐ (2) I have been advised by a health care provider to self-quarantine due to COVID-19 (FML EXP)
Name of the advising healthcare provider: _____

☐ (3.A) I have symptoms related to COVID-19 and I am seeking (or have sought) a diagnosis; (FML EXP); or
☐ (3.B) I am seeking or awaiting the results of a diagnostic test for, or a medical diagnosis of, COVID-19 because I have been exposed or because my employer has requested the test or diagnosis; (FML EXP)
☐ (3.C) I am obtaining a COVID-19 vaccinnation or I am recovering from adverse reactions related to a COVID-19 vaccine (FML EXP)

☐ (4) I am caring for another person who is isolating or quarantining on government or doctor's orders (FML EXP)
Name of the person I am caring for and our relationship: _____
Name of the government entity issuing the order: _____
OR Name of the advising healthcare provider: _____

☐ (5) I need to care for my child (age 17 and under) because the child's school, child care or child care provider is closed or unavailable because of COVID-19 (FML EXP)
Name(s) and age(s) of child(ren): _____
Name of closed school(s) or place(s) of care: _____

☐ (6) I am experiencing other conditions substantially similar to COVID-19 as specified by HHS. (FML EXP)
Attach documentation from medical provider or school/child care provider as applicable.

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 certify that the above information is truthful and understand that misrepresenting my need for leave is grounds for discipline, up to and including termination of employment.

Employee Signature: _____ **Date:** _____

_____ _____
Human Resources Signature Date