

# RCUH **Expanded** Family Medical Leave Request Form (Form B-11EFML)

(FFCRA Leave - Care for Self or Family Member)

**(Effective from April 1, 2020 through December 31, 2020 for Working Employees)**

**INSTRUCTIONS:** Please complete this form and submit with the RCUH Form D-48EPSL and supporting documents (if applicable) via encrypted email or by fax (808) 956-5022 (RCUH Employee Benefits fax number). **NOTE:** If approved your Expanded Family Medical Leave runs concurrently with your 12-week FMLA benefit entitlement (if applicable).

**Section I: Employee/Project Contact Information: Please fill out all blanks requested below:**

Employee Name:	RCUH Employee ID#:
Daytime Phone #:	Email:
PI Name:	Email:
Time Keeper Name:	Email:

**Section II: Leave Request Information: The **Expanded** Family Medical Leave benefit is only available between April 1, 2020 through December 31, 2020.**

A. Please select if leave is  Continuous  Intermittent (Requires PI Approval)

B. **Start Date of Leave:** \_\_\_\_\_ **Expected Return to Work Date:** \_\_\_\_\_

**C. Please select the applicable box(es) below indicating the reason for your Family Leave request.**

- 1. **Own Serious Health Condition or Quarantine or Isolation Order** (Attach RCUH Form D-48EPSL. May be required to complete a WH-380E form.)
- 2. **Serious Health Condition of a Family Member:** For My Child, Spouse/Reciprocal Beneficiary/Civil Union Partner, Sibling or Parent (includes parents-in-law, grandparents, and grandparents-in-law). **Attach RCUH Form D-48EPSL. May be required to complete a WH-380F form.**
- 3. **Caring for child:** Child's school or place of care is closed (or child care provider is unavailable) due to COVID-19 related reasons. **Attach RCUH Form D-48EPSL.**
- 4. **Other Circumstance:** Experiencing any other substantially-similar condition specified by the U. S. Dept. of Health & Human Services.  
**Specify:** \_\_\_\_\_

**Section III: Employee Certification:** I certify that the information provided on this document and other related document is accurate. I acknowledge any falsification of information could result in my termination of employment.

A. Print Name & Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Section IV: Principal Investigator Acknowledgement/Approval:** I acknowledge this is consider a protected leave.  (Check box if you approve the employee taking intermittent leave as noted above)

A. PI/Supervisor's Print Name & Signature: \_\_\_\_\_ Date: \_\_\_\_\_

*Please return this form via email to RCUH Benefits at rcuh\_benefits@rcuh.com or via fax at (808) 956-5022 at least ten (10) working days before the requested start date of leave or as soon as possible (if leave is not foreseeable). RCUH Benefits will provide you a determination of your eligibility within five (5) business days of receipt of your EFML Form.*