



**EMERGENCY FAMILY LEAVE ACT
REQUEST FORM
Telemedicine**

DATE: _____

EMPLOYEE NAME: _____

Department: _____ **Position:** _____

Date of Telemedicine Virtual Appointment: _____

Appointment of for self _____ or family member _____

Reason for Appointment:

- ☐ Possible need to self-quarantine because of COVID19;
- ☐ Experiencing symptoms of COVID19 and is seeking a medical diagnosis and possible testing;
- ☐ Contracted illness and unsure if this is potentially COVID19 or other virus.

Instructions: Please attached care note from your TELADOC patient electronic health record or if you are using an alternate Telemedicine option a care note from there. This information is confidential to Human Resources. Do not provide a copy to your supervisor. HR will follow up with your supervisor once approved.

Employee Signature: _____ **Date:** _____

***Please submit form and leave request to HR via fax (208) 265-1457 or email
hr@bonnercountyid.gov.***