**EMPLOYEE REQUEST FOR EMERGENCY FAMILY MEDICAL LEAVE**

**FOR COVID-19 QUALIFYING REASON**

To request leave pursuant to the Emergency Family and Medical Leave Expansion Act (EFMLEA) under the Families First Coronavirus Response Act (FFCRA), you must complete this request form and submit it to the Human Resources Department as soon as possible. All requested information supporting the need for leave must be provided with this request.

**Notice:**  If you are unable to submit the form prior to commencement of your leave, verbal notice will be accepted until this form and the required information can be provided. However, if you have not provided this form, after the first workday of paid leave time, you will be provided notice and given the opportunity to submit proper documentation to ensure your eligibility prior to any action being taken to deny your leave for failure to follow reasonable notice procedures.

**EMPLOYEE NAME**

Employee Name (print clearly): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Department: \_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Manager/Department Head: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**DATES OF LEAVE**

Requested Leave Start Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ End Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The amount of emergency Family Medical Leave being requested is \_\_\_\_\_\_\_\_\_\_ hours.

**QUALIFYING REASON FOR LEAVE**

I am requesting this emergency leave due to my inability to work (or telework) because I am caring for my child (or children) whose primary or secondary school or place of care has been closed or my childcare provider is unavailable for COVID–19 reasons.

In support of this request, please provide the following information:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Full Name, Relationship, and Age of Minor Child Being Cared For

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name, Address, Phone Number of Unavailable School, Place of Care, or Child Care Provider

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Full Name(s), Relationship(s), and Age(s) of Other Child(ren) Being Cared For

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name, Address, Phone Number of Unavailable School, Place of Care, or Child Care Provider

**Required Attestation Regarding Childcare**

I attest that no other suitable person is available to care for my child(ren) during the requested period of leave.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employee Signature Date

Please advise whether you request consideration for intermittent leave:

❏ I would be interested in taking intermittent leave to care for my child(ren).

❏ I am not interested in taking intermittent leave to care for my child(ren).

Please advise whether you request to use Emergency Paid Sick Leave for the first two weeks of the leave and/or other accrued personal leave time for the remainder of the leave:

❏ I request to utilize Emergency Paid Sick Leave during the first two weeks of

my leave to care for my child(ren).

❏ I request to utilize additional accrued personal leave during the first two weeks of my leave to care for my child(ren) or during the remainder of the leave as follows:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CERTIFICATION & ACKNOWLEDGEMENT**

In submitting this request for expanded Emergency Family Medical Leave benefits, I certify that the information is true and accurate to the best of my knowledge. I acknowledge and understand that providing false or misleading information regarding the need for leave under the EFMLEA or any FFCRA qualifying event may be grounds for corrective action, up to and including termination.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employee Signature Date

Received By:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Human Resources Signature Date

For HR use only: Specify whether the leave is approved or denied (and state reasons if denied), the details of leave, including whether intermittent leave is granted, use of Emergency Paid Sick Leave, and/or use of accrued personal leave, etc.:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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