**Emergency Family and Medical Leave Act: Employee Request for Leave Form[[1]](#footnote-1)**

*This form must be completed and returned to \_\_\_\_\_\_\_\_ before any request for leave under the Emergency Family and Medical Leave Act (the "EFMLA") will be approved. Questions about the EFMLA or this form should be directed to \_\_\_\_\_\_\_.*

Employee Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Today's Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason for Leave Request:

* Closure of your child's school, due to COVID-19
* Closure of your child's place of care, due to COVID-19
* Your child's care provider is unavailable, due to COVID-19

Date Requested Leave is to Begin: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, 2020.

Date Requested Leave Will End: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, 2020.

*EFMLA is only available for use from April 1, 2020, through December 31, 2020, and only for a qualifying reason occurring during that period.*

Are you Requesting Intermittent Leave: Yes \_\_\_ No \_\_\_

If yes, please explain the requested intermittent periods of leave: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(*The company will determine whether or under what conditions intermittent EFMLA will be allowed. Applicable limitations will be discussed with you when your request is processed.*)

Required Information Supporting Reason for Leave:

* You are unable to work or telework due to the COVID-19 reason indicated above because: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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* Child(ren)’s name(s) and age(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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* Name(s) of school(s) or place(s) of care that has been closed or name of care giver who is unavailable: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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* You confirm that no other person will be providing care for the child during the period for which you would be receiving EFMLA leave. \_\_\_\_\_\_\_ (initial).
* For a child 15 years of age or older, you confirm that you are unable to work or telework during daylight hours because special circumstances exist requiring you to provide care. \_\_\_\_\_\_ (initial)

The First Two Weeks are Unpaid Unless You Request to Use Some Type of Paid Leave. Are You Requesting Any of the Options Below?

I request to use Leave under the Emergency Paid Sick Leave Act, which leave benefits will be paid at 2/3rds of my usual pay, to a maximum of $200 per day:Yes \_\_\_ No \_\_\_

I request to use my available paid leave under company policy, which will be paid in accordance with policy:Yes \_\_\_ No \_\_\_

If I elect to use company policy leave and do not have sufficient paid leave available for the full two weeks, after I have exhausted my company paid leave: I will take unpaid leave: \_\_\_\_\_\_ I will utilize Emergency Paid Sick Leave Act leave \_\_\_\_\_\_ (choose one).

[ALTERNATIVE FINAL PARAGRAPHS—to be determined by employer]

Alternative 1:

Subsequent EFMLA Weeks are Paid at 2/3rds Pay

Regardless of whether you elect to use paid leave for the first two weeks of EFMLA leave, subsequent EFMLA leave will be paid at 2/3rds your usual pay, to a maximum of $200 per day.

*Note that this provision applies only to EFMLA leave, and not any other type of FMLA leave*.

Alternative 2:

Subsequent EFMLA Weeks Are Paid Per Your Election:

After the expiration of the initial two (2) weeks, the subsequent EFMLA leave is paid until your leave allotment is exhausted. You may choose one of these two options:

Please pay me under the EFMLA required benefits, which I understand are 2/3rds my usual pay to a maximum of $200 per day:Yes \_\_\_ No \_\_\_

Please utilize my available PTO at my full pay until the PTO is exhausted, after which I will be paid at 2/3rds my usual pay to a maximum of $200 per day: Yes \_\_\_ No \_\_\_

*Note that this provision applies only to EFMLA leave, and not any other type of FMLA leave*.

Alternative 3:

Subsequent EFMLA Weeks Are Paid As follows:

You will be required to utilize company provided PTO until exhausted. After you have exhausted available PTO, your EFMLA will be paid at 2/3rds your usual pay to a maximum benefit payment of $200 per day.

*Note that this provision applies only to EFMLA leave, and not any other type of FMLA leave*.

I certify that the information I have provided is accurate. I understand that it is my responsibility to notify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ immediately if there is any change to my leave request above.

Employee signature Date

1. Do not use this form to request FMLA for one of the standard qualifying events, such as your own serious illness. Please use the company’s standard FMLA leave request form for any FMLA request other than EFMLA. [↑](#footnote-ref-1)