Expanded Family and Medical Leave To Care For Children

Name: _____ Date: _____

Cell Phone:_____ Email: _____

I hereby certify that I am unable to work/telework and need to use Emergency Paid Sick Leave and/or Expanded Family and Medical Leave to care for a child under 18 years of age because his/her school or place of care has been closed or child care provider is unavailable or a child over 18 who is disabled and unable to care for him/herself. Please Provide the following information:

Name(s) and date(s) of birth of child/ren:_____

_____

Name(s) of Closed School(s) or Place(s) of Childcare:_____

_____

Name of Unavailable Childcare Provider(s): _____

If the child and/or children needing care during daylight hours are over the age of 14, please provide a statement of special circumstances that exist requiring care:_____

_____

I hereby certify and represent that no other person will be providing care for the child/children during the period for which I am receiving paid leave. _____(Employee initials)

Emergency Paid Sick Leave: I understand that I am entitled to up to 80 hours/2 weeks of paid sick leave at 2/3 of my regular pay to a maximum of $200 per day or $2,000 in total to care for my child/ren due to school or childcare closure or unavailability of childcare provider or to care for a disabled child who is incapable of self-care. That paid sick leave will run concurrently with the first 2 weeks of expanded family and medical leave.

I have used emergency paid sick leave for a reason other than the care of my children. Yes_____ No_____

I request that my accumulated time (sick/personal/vacation) if applicable, be used to make up the difference so that I receive my full pay. Yes_____ No_____

Expanded Family and Medical Leave. I understand that I am entitled to up to 10 weeks of paid leave at 2/3 of my regular pay to a maximum of $200 per day or $2,000 in total to care for my child/ren due to school or childcare closure or unavailability of childcare provider or to care for a disabled child who is incapable of self-care.

I have not used any FMLA leave in the last 12 months Yes_____ No_____

I request that my accumulated time (sick/personal/vacation) if applicable, be used to make up the difference so that I receive my full pay. Yes_____ No_____

First Date of Leave: _____Anticipated Return to Work Date: _____

I understand that I may be required to provide additional documentation and/or a fitness to return to work certification. I acknowledge that it is my responsibility to contact _____ at _____ prior to returning to work. I also understand that if I am unable to return to work/telework on the above date, I must obtain approval for an extension of my leave. I certify that the information provided herein is accurate and true.

Signature:_____Date:_____