## HUMAN RESOURCES DEPARTMENT

### REQUEST FOR COVID-19 EXTENDED FAMILY MEDICAL LEAVE

Employee Name: _____ Date: _____

Department: _____

You are eligible for twelve (12) weeks of Family Medical Leave if you are caring for a child whose school or place of care is closed (or child care provider is unavailable) for reasons related to COVID-19, provided you are unable to work, as verified by your supervisor.

***Please provide name of child(ren):*** _____

Elect one of the following for your first two (2) weeks of leave:

- ☐ Paid COVID-19 Sick Leave
- ☐ Leave without pay
- ☐ Your accrued Sick _____, Vacation _____, or Comp Time _____.

**(Indicate number of hours of each)**

The remaining time for which you are eligible will be paid without using your accrued leave.

This leave may be taken on an intermittent basis. Please specify the dates for this request and the hours per week you will utilize.

Start Date: _____ End Date: _____ Hours per Week: _____

I certify that _____ has been closed and/or my child care
***(Name of School)***

provider is unavailable due to COVID-19 concerns.

Signature: _____ Date: _____

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I have reviewed the employee's request for leave and verify that the employee is unable to perform work remotely.

Supervisor: _____ Date: _____

**Please submit to your Supervisor, who will review, approve and submit to HR.**