

**EMERGENCY FAMILY AND MEDICAL LEAVE EXPANSION ACT (EFMLEA)  
REQUEST FOR LEAVE**

Please complete and submit this form to Human Resources. Failure to provide the additional information as indicated in section (B) below may result in delaying or denying your request for leave under the Emergency Family and Medical Leave Expansion Act (“EFMLEA”). Once the Company receives and reviews the information from you, the Company will then inform you whether your leave will be designated as EFMLEA leave. For questions about this form or EFMLEA, please contact Human Resources.

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

Title/Position: \_\_\_\_\_

Reports To: \_\_\_\_\_

Date Form Submitted/Leave Requested: \_\_\_\_\_

(A) Please identify the reason(s) for the leave:

I am unable to work or telework because of:

- Closure of my child’s school for reasons related to COVID-19
- Closure of my child’s place of care for reasons related to COVID-19
- My child’s care provider is unavailable for reasons related to COVID-19

(B) Please provide the following information to support the reason(s) for the leave:

- I am unable to work or telework due to the COVID-19 reason indicated above because:

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

- Name(s) and age(s) of the child(ren): \_\_\_\_\_

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

- Name(s) of school(s) or place(s) of care that has been closed or name of care giver provider who is unavailable due to COVID-19 precautions: \_\_\_\_\_

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

- I confirm that there is no other suitable person to provide care for my child(ren) during the period for which leave is requested, and that if such child(ren) is older than fourteen, special circumstances exist requiring me to provide care. \_\_\_\_\_ (initial)

(C) Please provide the dates of the requested leave:

Leave to begin on: \_\_\_\_\_

Leave to end on: \_\_\_\_\_

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

(D) The first two weeks of EFMLEA leave are unpaid unless you request use of some type of paid leave. Please indicate your choice below.

- I am also requesting leave under the Emergency Paid Sick Leave Act (“EPSLA”) for the reason(s) identified above, which, if approved, will provide pay at 2/3 my regular rate of pay, up to a maximum of \$200 per day for up to the first two weeks.
- I request to use my available paid time off (e.g., vacation or sick time) under the Company’s paid time off policies. If I do not have sufficient paid time off available for the full two weeks, after I have exhausted such paid time off: (choose one)
  - I will take unpaid leave for the remainder of the first two weeks.
  - I will utilize EPSLA leave.
- I request to take the EFMLEA leave unpaid for up to the first two weeks.

*Note: If you are also requesting to use EPSLA leave during the first two weeks of the EFMLEA leave, please complete and submit an EPSLA leave request form along with this form. Please note that leave under EFMLEA and EPSLA will run concurrently during such period.*

*Note: After the first two weeks of EFMLEA leave, eligible employee are paid at 2/3 their regular rate of pay up to a maximum of \$200 per day for up to 10 weeks of EFMLEA leave.*

(E) Are you requesting intermittent leave?: Yes \_\_\_ No \_\_\_

If yes, please explain the requested intermittent periods of leave under the EFMLEA:

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*Note: The Company will determine whether your requested intermittent EFMLEA leave will be allowed.*

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I certify that the information I have provided in this form is accurate. I understand that it is my responsibility to notify Human Resources immediately if there is any change to my leave request above.

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Employee signature

Date