APPLICATION FOR EMERGENCY FAMILY AND MEDICAL LEAVE EXPANSION ACT (EFMLEA)

Effective April 1, 2020

PLEASE PRINT:

Name ______________________ Employee # ____________ Date ____________

Position ____________ Principal/Supervisor ____________ School/Department Name ____________

TYPE OF LEAVE: ☐ EMERGENCY FAMILY & MEDICAL LEAVE EXPANSION ACT (EFMLEA)

Name of Child	Date of Birth	School/Child Care Provider

I ______________________________________parent of the above named child/children attest that their school has closed and/or place of child care is no longer available. There is no other person that will be providing care for my child/children during the period for which I will be receiving either the Emergency Paid Sick Leave of Family Medical Leave under the Emergency Family Medical Leave Expansion Act. I cannot provide care for my child/children during daylight hours. If your child is over 14 years of age, please state the special circumstances for this request below.

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If approved for EFMLEA, select the type of leave to be used for Initial 10 days:

___ Accrued Sick Leave ____ Unpaid Leave ____Accrued Vacation Leave

READ EACH STATEMENT BELOW AND INITIAL: **Further documentation may be required.**

______ All EFMLEA leave requests will be subject to rules of the Families First Coronavirus Response Act (H.R. 6201).

______ Employee will need to contact Employee Benefits at (941) 708-8770 for questions related to current benefits.

______ Failure to return from an approved leave of absence will be considered a resignation.

______ **I certify that the above information is accurate and that I understand if I am approved, I may receive up to 12 weeks of leave. The first 2 weeks are unpaid and up to 10 weeks paid at 2/3 of my daily rate of pay with a cap of $200 per day and $10,000 in the aggregate. EFMLEA is subject to the employee 's remaining availability for leave under FMLA and understand that I am eligible for a total of 12 weeks of FMLA over the last 12 months of employment.**

Please submit completed application (required) and documentation (if required) to: absence@manateeschools.net

DATES ABSENT:

Start Date: ______________ End Date: ______________(If dates are unknown, leave blank)

Employee Signature: ________________________________ Date: ______________

HR/Benefits USE ONLY:

Date Received: _____________ Eligible: _________ Not Eligible: _________ HR/Benefit Initials: ___________

Supervisor Telework Verification: ____