EMERGENCY FAMILY AND MEDICAL LEAVE EXPANSION ACT

COVID 19: EFMLEA

EMPLOYEE INFORMATION

Name: ______________________ Date of Hire: ______________ EEID: ____________

Supervisor: ____________________ Division/Department: _________________________

Home Address: ______________________________________ Apt #: ____________

City: ____________ State: ________ Zip Code: _________ Email: __________________

Home Phone: ______________________ Cell Phone: ___________________________

ELIGIBILITY

To be eligible for EFMLEA, you must:

- Have worked for Orange County Government for at least 30 days prior to this request, and;
- Be unable to work because you are caring for a minor child/ adult child with a disability since your child's school or daycare is closed [or your childcare is unavailable] due to COVID-19 related reasons.

Note: An employee is only entitled to 12 weeks of FML in total during a 12 month period. If an employee has already exhausted their 12 weeks of FML during this 12 month period, he or she will not be entitled to any additional leave under EFMLEA during this same period.

LEAVE REQUESTED

Leave Start Date: ______________________ **Leave End Date**: ______________________

Shift ***(if applicable):*** ☐ **A** ☐ **B** ☐ **C** **How would you like us to contact you:** ☐ **Home** ☐ **Cell** ☐ **Email**

Utilize accrued leave for the first 2 weeks: ☐ **Yes** ☐ **No**

Utilize accrued leave to supplement 1/3 difference in pay (10 weeks): ☐ **Yes** ☐ **No**

Type of EFMLEA: ☐ **Consecutive** ☐ **Intermittent**

Number of Hour(s) Requested in Full Workday Increments: ______________________

CHILD / CHILDREN INFORMATION

- **Name of the child[ren] being cared for:** ______________________________________
- **Name of the school(s), place(s) of care or child care provider(s) that closed or became unavailable due to coronavirus reasons:** ______________________________________
- **Statement representing that no other suitable person is available to care for the child[ren] during the period of requested leave**: ______________________________________

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I certify that I am unable to work (or telework) because I am caring for a child who is 18 years of age or younger or an adult child who is 18 years of age or older, who (1) has a mental/physical disability, and (2) is incapable of self-care because of that disability. In addition, I also certify that the above statements are true and correct to the best of my knowledge and I understand that a false statement may disqualify me from EFMLEA.

Employee Signature: ________________________________ **Date:** ________________

Please submit completed form to your HR Representative

04/2020

F008 – FML - COVID-19