

**Request for Expanded FMLA Leave  
Families First Coronavirus Response Act**

To request expanded FMLA leave as provided under the Families First Coronavirus Response Act and Pulaski County's Expanded Family and Medical Leave Policy, please complete the following request form and submit to your supervisor or department head as soon as possible before leave commences. Verbal notice will be accepted until a form can be provided.

Documentation supporting the need for leave must be included with this request, as described in the FMLA Leave Expansion and Emergency Paid Sick Leave Policy.

Employee Name (print clearly): \_\_\_\_\_

Department: \_\_\_\_\_

Supervisor: \_\_\_\_\_

Requested Leave Start Date: \_\_\_\_\_ End Date: \_\_\_\_\_

I am requesting this expanded FMLA leave due to my inability to work (or telework) because I am needed to care for my child due to:

- The closing of my child's school or place of care, due to concerns related to COVID-19.
- The unavailability of my child's regular child care provider due to concerns related to COVID-19.

Furthermore,

- I attest that no other suitable person is available to care for my child during the requested period of leave.
- I attest special circumstances exist requiring my need for leave to care for a child ages 15-17.

Time off work is expected to be (select the most appropriate box):

- For a continuous block of time.
- For a reduced work schedule (change in work schedule needed—fewer hours per day or fewer hours per week).

If a reduced work schedule is needed, indicate the days and hours you are available for work:

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

I have attached appropriate documentation supporting my need for leave.

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Elected Official/Supervisor Signature: \_\_\_\_\_ Date: \_\_\_\_\_

HR Department Rep. Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Employee Statement Supporting Leave**

I, \_\_\_\_\_, provide the following information in support of my request for expanded Family and Medical leave (complete all that apply):

**Name of school or place of care closed due to concerns related to COVID-19:**

\_\_\_\_\_

**Name of child caregiver unavailable due to concerns related to COVID-19:**

\_\_\_\_\_

**Name and age of child or children I am needed to care for:**

Name: \_\_\_\_\_ Age: \_\_\_\_\_

Name: \_\_\_\_\_ Age: \_\_\_\_\_

Name: \_\_\_\_\_ Age: \_\_\_\_\_

Name: \_\_\_\_\_ Age: \_\_\_\_\_

**No other suitable person is available to care for my child for the requested leave period due to:**

\_\_\_\_\_

\_\_\_\_\_

**The special circumstances requiring my need for leave to care for a child ages 15-17 are:**

\_\_\_\_\_

\_\_\_\_\_

Employees eligible for Expanded FMLA Leave as provided by the FFCRA will be paid at a rate of 2/3 their salary.

**I wish to supplement my pay with my accrued sick and vacation hours.**  Yes  No

I hereby declare, attest, and verify that the above information is accurate and complete. I understand that, based on this information, I may receive monetary benefits and/or leave from my employer that I would not otherwise be eligible to receive. I further understand that my employer is relying on the truthfulness of this information. I understand falsification of any information given may lead to disciplinary action.

**Employee Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_