City of Palm Bay

COVID-19 2.0 EXPANDED FAMILY AND MEDICAL LEAVE ACT FORM

Name: _____

NOTE: The Emergency Paid Sick Leave Act provides for up to 2 weeks of paid leave at 2/3 the employee's regular rate of pay; use the EMERGENCY PAID SICK LEAVE ELECTION FORM to request the initial 2 weeks.

To request additional time, up to 10 additional weeks of paid leave, complete this form:

I elect to take paid family medical leave under the Expanded Family and Medical Leave Act (EFMLA) implemented in response to the public pandemic COVID-19 from _____ until _____. I certify through this request that I have not taken 12 workweeks of leave under the Family Medical Leave Act (FMLA) over the past 12-month period. If I have taken leave in the past 12 months under the Family Medical Leave Act, I understand that only remaining leave is available for this purpose.

I am requesting leave under this policy because I have a Qualifying Need. A Qualifying Need means I am unable to work (including telework) due to a need to care for my son or daughter who is either

1) under 18 years of age, or

2) incapable of self-care because of a mental or physical disability

because the child's school or place of care has been closed, or the child's care provider is unavailable, due to a Public Health Emergency.

I have attached the required documentation (*) in support of my Expanded Family and Medical Leave taken to care for my child whose school or place of care is closed, or childcare provider is unavailable, due to COVID-19-related reasons. (This requirement may be satisfied with a notice of closure or unavailability from my child's school, place of care, or child care provider, including a notice that may have been posted on a government, school, or day care website; published in a newspaper; or emailed to me from an employee or official of the school, place of care, or child care provider.)

Name of child/ren cared for: _____ *(please print)*

***Name of school or, place of care, or childcare provider that closed or became unavailable due to COVID-19 related reasons: _____**

I, _____ *(please print)* **attest that no other suitable person is available to care for child/ren during the period of requested leave.**

This paid family medical leave shall cease beginning with my scheduled work shift immediately following the termination of the Qualifying Need for family medical leave identified above.

If I wish to change these elections or have any questions, I will contact the Human Resources Department at 321.952.3421 as soon as practicable.

Employee Signature: _____ Date: _____