City of Delano

Emergency Family and Medical Leave Expansion

AND

Emergency Paid Sick Leave

Request Form

Employee Name: _____ Date of Request: _____

Department: _____ Position Title: _____

Hire Date: _____

I request leave for the following reason(s) (check one):

Two 2 weeks of Emergency Paid Sick leave for the following reason:

___ **A**. I am subject to a Federal, State, or Local quarantine or isolation order related to COVID-19;

___ **B.** I have been advised by a health care provider to self-quarantine due to concerns related to COVID-19;

___ **C.** I am experiencing symptoms of COVID-19 and seeking a medical diagnosis;

___ **D**. I am caring for an individual who is subject to an order as described in "A" above or has been advised as described in "B" above;

___ **E**. I am caring for a son or daughter that the school or place of care of my son or daughter has been closed, or the child care provider of such son or daughter is unavailable, due to COVID-19 precautions;

For E. you must provide the following information:

Name of child #1 being cared for: _____

Name of School, Place of Care, or Care Provider name: _____

Phone: _____

Name of child #2 being cared for: _____

Name of School, Place of Care, or Care Provider name _____

Phone: _____

Name of child #3 being cared for: _____

Name of School, Place of Care, or Care Provider name _____

Phone: _____

If more than three children, please provide the information on the back of this sheet and check this box ☐.

I understand that I will be required to recertify every week during my leave for if my leave is pursuant to"E"above.

I further understand that if taking leave pursuant to "E" above, the leave will run concurrent with the Emergency Family and Medical Leave Expansion Act (EFMLEA) which will afford me up to 10 additional weeks of paid leave of up to two-thirds my pay (subject to limitations) for a total of 12 weeks of protected EFMLEA.

I certify that there is no other suitable person available to care for my child(ren) during the period in which I am requesting to take Paid Sick Leave and/or Expanded Family and Medical Leave. _____
Initials

Date leave to begin: _____ Date Leave to End: _____

_____ _____

Signature Date