COVID-19 Emergency Family and Medical Leave Request

Name: ____ Date of Hire ______________________________

Job Title:______________________________________ Supervisor: _____________________________________

Anticipated Start Date for Leave: _________________ Number of Weeks Requested (12 max): _______________

I certify that I am unable to work due to a need to care for my son or daughter, under 18 years of age, because the school or place of care has been closed or the child care provider is unavailable, because of a public health emergency.

Employee Signature_______________________________________ Date________________________

Eligibility Affirmed ____

Approved By: ____ Date________________________

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<u>Calculation of Paid Leave</u>

First Day of Leave ______________________ First Day of *Paid* Leave _________________________

Employee's Hourly Rate of Pay $__________ Two-thirds Hourly Rate of Pay $_________________

Weekly Hours Worked __________________ Amount of Pay Per Pay Period $_________________

Paid Leave Ends _______________________

Cost of health insurance coverage per pay period $__________________.