City of FRESNO

REQUEST FOR EMERGENCY FAMILY/MEDICAL LEAVE

Employee's Name: _____

Employee ID: _____ ☐ Perm ☐ PPT ☐ Temp Date of Request: _____

Employee's Address: _____

_____

Department/Division: _____

Job Title: _____ Hire Date: _____

I request an Emergency Family/Medical Leave pursuant to the Family/Medical Leave Expansion Act to care for my son(s) or daughter(s) by the name of: _____ under the age of eighteen due to their school or place of care being closed or child care provider is unavailable due to a public health emergency and the employee is unable to work or telecommute due to the qualifying reasons. (Please attach school or daycare provider closure notice)

Method of Leave Requested
(Please check one)

☐ Consecutive Leave beginning on _____Expected Duration:_____

☐ Intermittent Leave beginning on _____Expected Duration:_____
(Specify schedule below)

Frequency/Duration: _____

☐ Reduced or Modified Schedule (Specify schedule below)

_____hour(s) per day;_____days per week from _____through _____

The first ten days of the Emergency Family/Medical Leave Expansion Act is unpaid. Beginning on the eleventh day of the leave, the Emergency FMLA is paid at 2/3rd the usual salary up to $200 per day and a maximum of $10,000 in total.

☐ I hereby authorize the integration of my available leave balances in accordance with my respective MOU or salary resolution during this period and integrate my leave balances going forward.

☐ I do NOT wish to integrate my available leave balances in accordance with my respective MOU or salary resolution during this period.

I attest no other suitable person is able to for my son(s) and/or daughter(s) during the period of Emergency Family Medical Leave.

Employee Signature_____Date _____