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**(NAME OF ORGANIZATION)**

**FAMILIES FIRST CORONAVIRUS RESPONSE ACT FMLA LEAVE ELECTION FORM**

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

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

I elect to take paid family medical leave under the Families First Coronavirus Response Act (FFCRA) from \_\_\_\_\_ until \_\_\_\_\_ (maximum of twelve weeks total noting that the first 10 days are unpaid).

I have taken \_\_\_\_ weeks of leave under the Family Medical Leave Act over the past 12 month period. Thus, I have \_\_\_\_ weeks of FMLA remaining to be used for EFMLA.

I \_\_\_\_ am an eligible employee. I \_\_\_\_ am not an eligible employee.

I am requesting leave under this policy because I have a Qualifying Need. A Qualifying Need means I am unable to work (or 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 child care 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.)

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.

I understand that FMLA taken for this purpose is to be paid at 2/3 of my regular rate. I wish \_\_\_\_\_ do not wish \_\_\_\_\_ to request that accrued PTO/ leave, if available, be used to cover the remaining 1/3 of my regular rate of pay during this time.

If I wish to change these elections or have any questions, I will call [number] at soon as practicable.

I certify that the information provided is accurate. I understand that if my employer learns that I have provided inaccurate or false information, I may be subject to discipline up to and including termination.

Employee signature: \_\_\_\_\_