Hilldale Public Schools
Application for Paid Sick Leave Pursuant to the
Emergency Family and Medical Leave Expansion Act (EFMLEA)

Name: _____ Date: _____

Address: _____

Phone #: _____ Email: _____

Position: _____ Site: _____

Anticipated Begin Date of Leave: _____

Expected Return to Work Date: _____

The Emergency Family and Medical Leave Expansion Act provides for up to 12 weeks of job-protected leave for an employee, employed by the District for at least 30 calendar days. To qualify for this job-protected leave, you must be unable to work (or telework) due to a need for leave to care for a son or daughter, under 18 years of age or older but incapable of self-care because of a physical or mental disability, if the child's school or care provider is unavailable due to a public health emergency. **NOTE: the EFMLEA expands the reasons for which family and medical leave is available but does not provide additional family and medical leave in excess of the 12 weeks available under traditional FMLA. If you have used any or all of your entitlement to FMLA leave during the designated period this may affect your entitlement to emergency family and medical leave.**

Name of child(ren):

_____

Age of the child(ren):

_____

(If under 18 years of age or older but incapable of self-care because of a physical or mental disability)

Relationship of child(ren) to you:

_____

School or child care provider which has either closed or become unavailable:

_____

By signing this form I certify that:

- no other suitable person is available to care for the child(ren), identified above, during the period of leave requested;
- no other person will be providing care for the child(ren) during the period for which I am receiving family medical leave; and

- for any child(ren) identified above who is older than 14 years of age, special circumstances exist which require me to provide care during daylight hours.

IF AVAILABLE please submit with this completed form any documentation you may have at this time evidencing the closure for your child's school or child care facility.

Dated this _____ day of _____ 2020.

I certify that the information contained within this form is true and correct to the best of my knowledge. I authorize the District to obtain and verify any necessary information regarding my request. I understand that providing false information may result in corrective action up to, and including, termination of my employment or other penalties as permitted by law.

_____

Employee's Signature

To be Completed by District Personnel

Request is: ☐ Approved ☐ Denied

Staff member: _____

Date: _____