EMERGENCY FAMILY MEDICAL LEAVE AND EXPANSION ACT ATTESTATION & REQUEST FORM

COLLEGE: _____

Full-Time and Part-Time employees may be entitled to 12-weeks of job protected leave and continued health coverage if they are unable to work or telework because they are needed to care for their son or daughter because the child's school or childcare facility has been closed or the child's childcare provider is unavailable due to the public health emergency.

To request Emergency FMLA Expansion as provided under the Families First Coronavirus Response Act (FFCRA), please complete the following request form and attestation and submit to your human resources department as soon as possible.

Employee Information:

Empl. ID: _____

Name: _____

Department: _____

Contract Title: _____

Supervisor Name: _____

Phone: _____ Email: _____

Contact While on Leave: Cell Phone: _____

Home Phone: _____ Email: _____

Check One: ☐Full-Time ☐ Part-Time Numbers of Hours Worked per Week: _____

I am requesting this expanded FMLA leave due to my inability to work (or telework) because I am needed to care for my child due to:

- ☐ The closing of my child's school or place of care, due to concerns related to COVID-19.
- ☐ The unavailability of my child's regular child care provider due to concerns related to COVID-19.

Furthermore,

- ☐ I attest that no other suitable person is available to care for my child during the requested period of leave.
- ☐ I attest special circumstances exist requiring my need for leave to care for a child over the age of 14. .

Period of Leave Requested:

☐ **I request CONTINUOUS FMLA LEAVE:**

Leave Start Date: _____ Leave End Date: _____

☐ **I request INTERMITTENT FMLA LEAVE:**

Leave Start Date: _____ Leave End Date: _____

Number of hours/ week: _____

Anticipated schedule of absence must be discussed with supervisor. For Intermittent or Reduced Work Schedule, appropriate documents must be attached.

FMLA Time Used Last 12 Months:

Check One: ☐ No ☐ Yes From: _____ To: _____

Employee Statement Supporting Leave

I, _____, provide the following information in support of my request for expanded Family and Medical leave (complete all that apply):

Name of school or place of care closed due to concerns related to COVID-19: _____

Name of child caregiver unavailable due to concerns related to COVID-19: _____

Name and age of child or children I am needed to care for:

Name: _____ Age: _____

Name: _____ Age: _____

Name: _____ Age: _____

I, _____, attest that no other suitable person is available to care for my child or children during the period of requested leave.

☐ I attest that special circumstances exist requiring my need for leave to care for a child over the age of 14.

I understand that the initial 2 weeks (10 days) of Emergency FMLA Expansion is unpaid. I elect to be paid for the first 10 days under the Emergency Paid Sick Leave Act. **Check one:** ☐ Yes ☐ No

I elect to substitute my accrued paid time under my employer benefits after the initial 2 weeks.
Check one: ☐ Yes ☐ No ☐ N/A

I attest that the above information is accurate and complete. I understand falsification of any information given may lead to disciplinary action.

I understand that providing false or misleading information regarding the need for Emergency Family Medical Leave or any Families First Coronavirus Response Act qualifying reason will be grounds for appropriate action, which could include discipline up to and including termination of employment in accordance with applicable CUNY policies and collective bargaining agreements.

Employee Signature: _____ Date: _____

For Human Resources Use Only

HR Representative Name: _____

HR Representative Signature: _____ Date: _____