City of Milwaukee DER
EMPLOYEE REQUEST FOR EMERGENCY FAMILY AND MEDICAL LEAVE

Employees requesting Emergency FMLA (EFMLA) pursuant to the Families First Coronavirus Response Act (FFCRA) must complete this form. You must provide as much advance notice as is reasonably practicable. Upon completion of this form, submit it to your Departmental FMLA Leave Administrator for processing.

Employee Name:	**Employee ID No.:**
Employee Home Address:	**E-mail:**
Home Phone Number:	**Phone Number:**
Department/Division:	

This is a *(choose one)*: ☐ New request for leave ☐ Request for an extension of leave

Anticipated Begin Date of Leave: **Expected Return to Work Date:**

Reason for Leave (*check all applicable*) I am unable to work (or telework) for the following reasons:

☐ I need to care for my son or daughter under age 18 because my child's elementary or secondary school has been closed due to a public health emergency and no one else is available to provide care.
  Name(s) and age(s) of child/children: _____
  Name of school: _____

☐ I need to care for my son or daughter under age 18 because my child's place of care has been closed due to a public health emergency and no one else is available to provide care.
  Name(s) and age(s) of child/children: _____
  Name of place of child care: _____

☐ I need to care for my son or daughter under age 18 because the child care provider for my son or daughter is unavailable because of a public health emergency and no one else is available to provide care.
  Name(s) and age(s) of child/children: _____
  Name of child care provider: _____

I will need *(choose one)*:   ☐ Continuous leave   ☐ Intermittent leave

If your need for leave is intermittent, please describe the nature of your intermittent leave:

_____
_____

Substitution of Paid Leave: *Pursuant to the FFCRA, the first 10 days of your leave is unpaid, however you may be eligible for emergency sick leave provided through the FFCRA. In the event you are not*

eligible for emergency sick leave, you are permitted to use available paid leave to cover this period. Please indicate if you would like to use paid leave during the first 10 days of your absence (if you are not eligible for emergency sick leave) and how many hours you plan to use.

☐ Emergency Paid Sick Leave (_____ Hrs)
☐ Vacation (_____ Hrs) ☐ Comp (_____ Hrs) ☐ TVA (_____ Hrs)☐ Unpaid (_____ Hrs)

I certify that the above information is accurate and complete. I understand that if I fail to report for work on or before the scheduled return date indicated above or fail to contact Departmental FMLA Leave Administrator regarding my absence from work beyond such scheduled date of return, I may be subject to discipline.

Employee Signature: _____   **Date:** _____