CITY OF EL PASO, TEXAS

Human Resources Department

Request for Expanded Family and Medical Leave

*Expanded FMLA is only available for employees who have been employed with the City of El Paso for at least **30 calendar days**

NAME (Last, First, Middle Initial): (Type or Print in ink)	SOCIAL SECURITY #: (Last 6) **XXX - -**	KRONOS ID#:
DEPARTMENT:		DATE: Click or tap to enter a date.

Start Date of Anticipated Leave: Click or tap to enter a date.

Expected Date of Return to Work: Click or tap to enter a date. ☐ Intermittent Leave

REASON FOR REQUEST:

I am unable to work (or telecommute) due to a need for leave to care for my son or daughter **BECAUSE** the school or place of care has been closed, or the child care provider of such son or daughter is unavailable, due to a public health emergency with respect to COVID-19. I attest that I am the person caring for my child during the requested period and no other co-parent, co-guardian or usual child care provider is available to provide the care my child needs.

a. Child(ren)'s name(s)and age(s):____

b. Name of School/Daycare/Child Care Provider: ________________________________

Is Your Spouse a City Employee? ☐ Yes ☐ No

If Yes, Name: ______________________________

Department Working In: ______________________________

NOTE: I understand that the first 2 weeks are unpaid unless I elect to use any available emergency paid sick leave or my leave accruals. I understand that the information provided may be subject to verification at any time.

I understand that a failure to return to work at the end of my leave period may be treated as a resignation unless an extension has been agreed upon and approved in writing by the City of El Paso. I understand that my signature indicates that the above information is true and correct.

☐ I have available up to 12 weeks of FMLA leave (I have not exceeded 12 weeks of leave in the past rolling 12 months for either FMLA or expanded FMLA).

☐ I am electing to have the first 2 weeks unpaid.

☐ I am electing to have the first 2 weeks paid as Emergency Paid Sick Leave (compensated at 2/3's my regular rate of pay (with a cap of $200/day) or minimum wage (whichever is greater)

☐ I am electing to have the first 2 weeks paid from my accrued leave (WDO, Vacation, Sick)

The remaining 10 weeks of expanded FMLA leave are only available to be compensated at two-thirds my regular rate of pay (with a cap of $200/day) or minimum wage (whichever is greater).

EMPLOYEE'S SIGNATURE:	DATE: Click or tap to enter a date.
SUPERVISOR'S SIGNATURE:	DATE: Click or tap to enter a date.
DEPARTMENT HEAD SIGNATURE:	DATE: Click or tap to enter a date.

IF APPLICABLE, CHECK BELOW:	Employee Information:	DISTRIBUTION:
☐ Employee wants a copy of this form	Date of Hire: __________	Original – Human Resources
☐ Employee not available to sign this form	Prior FMLA taken: ______________	Copy – Department, Employee

TO BE COMPLETED BY HUMAN RESOURCES ONLY Date:________________ Initials: _______

☐ FMLA Letter: From: Click or tap to enter a date.___ To: Click or tap to enter a date._____

☐ Intermittent: From: Click or tap to enter a date.___ To: Click or tap to enter a date._____

☐ Employee was hired 30 calendar days prior to leave start date

☐ Denied:____

Notes: ____