

**EMERGENCY FAMILY AND MEDICAL LEAVE EXPANSION ACT (EFMLEA)  
REQUEST FOR LEAVE**

If you are unable to work (or telework) for reasons due to a COVID-19 circumstance described below, you will be paid at 2/3 your regular rate of pay up to a maximum of \$200 per day. EFMLEA leave is only available for use from April 1, 2020, through December 31, 2020, and only for a qualifying reason occurring during that period, for up to 10 weeks of EFMLEA leave.

Please complete and submit this form to Human Resources or your Supervisor. For questions about this form or EFMLEA, please contact Human Resources at [nhopkins@dudek-bock.com](mailto:nhopkins@dudek-bock.com)

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

Department: \_\_\_\_\_

Clock #: \_\_\_\_\_

Today's Date: \_\_\_\_\_

(A) Please identify the reason(s) for the leave:

I am unable to work or telework because of:

- Closure of my child's school for reasons related to COVID-19
- Closure of my child's place of care for reasons related to COVID-19
- My child's care provider is unavailable for reasons related to COVID-19

(B) Please provide the following information to support the reason(s) for the leave:

Name(s) and age(s) of the child(ren): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Name(s) of school(s) or place(s) of care that has been closed or name of care giver provider who is unavailable due to COVID-19 precautions: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I confirm that there is no other suitable person to provide care for my child(ren) during the period for which leave is requested, and that if such child(ren) is older than fourteen, special circumstances exist requiring me to provide care.

(C) Please provide the dates of the requested leave:

Leave to begin on: \_\_\_\_\_

Leave to end on: \_\_\_\_\_

(D) The first two weeks of EFMLEA leave are unpaid unless you request to use of some type of paid leave. Please indicate your choice below.

- I have taken 10 days of EPSLA leave previously.
- I request to use my available paid time off (e.g., vacation or sick time) under the Company's paid time off policies. If I do not have sufficient paid time off available for the full two weeks, after I have exhausted such paid time off I will take unpaid leave for the remainder of the first two weeks.

(E) Are you requesting intermittent leave?: Yes \_\_\_ No \_\_\_

If yes, please explain the requested intermittent periods of leave (for example only M-W-F) under the EFMLEA:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

*Note: The Company will determine whether your requested intermittent EFMLEA leave will be allowed.*

I certify that the information I have provided in this form is accurate. I understand that it is my responsibility to notify Human Resources immediately if there is any change to my leave request above.

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

\_\_\_\_\_  
Date