State of Vermont
Families First Coronavirus Response Act (FFCRA)

EMERGENCY FAMILY MEDICAL LEAVE EXPANSION ACT LEAVE REQUEST FORM

Last Updated: July 06, 2020

Employees who are caring for their child/children and who may be eligible for Emergency Paid Sick Leave (EPSL) and/or the Emergency Family Medical Leave Expansion Act (EFMLEA), should complete this form and return it to their Human Resources Business Partner (DHR Field Operations Representative) in order to support the request, for review and response. You can locate a list of all DHR Field Operations Representatives here: https://humanresources.vermont.gov/about-us/contact/hr-field-representative-locator

Individual situations will vary. It is important that employees work with their supervisors when considering the use of EPSL and/or EFMLEA. Supervisors must contact the Department of Human Resources Business Partner assigned to support their department/agency with questions concerning the specifics of their situation.

SECTION I: EMPLOYEE INFORMATION

Employee Name:____ Employee ID:__________________

Your Preferred Email Address:____

Your Preferred Phone Number:____

Your Current Mailing Address:____

____

Department:____

Name of Your Supervisor:____

SECTION II: DURATION OF LEAVE & REASON (*required field)

Anticipated Begin Date: *______________ Anticipated End Date: *____________________

I am requesting leave for the following reason (check applicable):

- ☐ I am caring for my child/children under age 18 whose school or place of care is closed or child care provider is unavailable due to COVID-19 related reasons
- ☐ I am providing care for my child/children age 18 or older with a disability and cannot care for themselves due to that disability, whose school or place of care is closed or child care provider is unavailable due to COVID-19 related reasons

SECTION III: INFORMATION REQUIRED TO SUPPORT LEAVE

A statement that you are unable to work or telework because of one of the above reasons:

The name and age of your child/children to be cared for (if the child is over 14 years old, you must explain the special circumstances exist requiring the employee to provide care):

The name of the school that has closed or place of care that is unavailable:

A representation that no other person will be providing care for your child/children during the period for which you are receiving family medical leave:

SECTION IV: EMPLOYEE AUTHORIZATION

- ☐ Intermittent Leave
- ☐ Full-time Leave

(I understand that I may be required to provide additional documentation at a later date)

Employee signature: ____ Date:_______________________

Human Resources Business Partner signature: __________________________Date: ________________