UNIVERSITY OF CALIFORNIA

IV. EXPANDED FAMILY AND MEDICAL LEAVE (EFML) REQUEST FORM
EFFECTIVE: April 1, 2020 through December 31, 2020
University of California

EMPLOYEE INFORMATION		
EMPLOYEE NAME	**EMPLOYEE ID**	**JOB TITLE**
REQUESTED EFML DATES **ENTER BOTH START AND END DATES**	**EFML START DATE**	**EFML END DATE**
LOCATION	**DEPARTMENT**	**SUPERVISOR**

If this is the first time you are taking EFML, complete sections A and B below.
If you have previously taken any EFML, skip section A and fill out section B.

Section A: Pay Options During the First Two Workweeks of EFML

During the first 2 workweeks of EFML (which are unpaid), I would like to:

☐ Use EPSL to receive pay (if I have not previously used EPSL) **NOTE: If checking this option, you should enter the same start date for EPSL and EFML.**

☐ Use UC Expanded Paid Administrative Leave to receive pay (if I have 2 workweeks remaining of that leave)

☐ Use the following type of accrued paid leave (such as vacation or PTO) to receive pay:

_____

☐ Use a combination of UC Expanded Paid Administrative Leave and accrued paid leave as follows:

_____

☐ Take leave without pay for these 2 workweeks

☐ Other: _____

Section B: Information to Support My Request for EFML:

Name and age of each *child* for whom I providing care:

_____

_____

There is no other suitable person besides me who will be caring for my *child*/children listed above during the period for which I am requesting EFML. Check here to confirm: ☐

The name of each *school* or *place of care* that is closed if that is the reason I am providing care for my *child*/children listed above:

_____

The name of each *childcare provider* that is closed/unavailable if that is the reason I am providing care for my *child*/children listed above:

_____

Section B: Information to Support My Request for EFML (CONTINUED):

If I have listed a *child* above who is older than 14 and I am providing care for that *child* during daylight hours, I am required to do that because of the following special circumstances:

_____

_____

If I have listed a *child* above who is 18 years or older, that *child* is incapable of self-care because of a mental or physical disability. Check here to confirm, if applicable: ☐

EMPLOYEE CERTIFICATION	
I certify that the foregoing is true. I understand that the University may require additional documentation in support of my request for EFML.	
EMPLOYEE SIGNATURE	**DATE**