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

<table>
<thead>
<tr>
<th>EMPLOYEE INFORMATION</th>
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<tbody>
<tr>
<td><strong>EMPLOYEE NAME</strong></td>
<td><strong>EMPLOYEE ID</strong></td>
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<tr>
<td><strong>REQUESTED EFML DATES</strong></td>
<td><strong>EFML START DATE</strong></td>
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<tr>
<td><strong>ENTER BOTH START AND END DATES</strong></td>
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<tr>
<td><strong>LOCATION</strong></td>
<td><strong>DEPARTMENT</strong></td>
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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.

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<thead>
<tr>
<th>EMPLOYEE SIGNATURE</th>
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