UNIVERSITY of HOUSTON

HUMAN RESOURCES

# Emergency Family and Medical Leave Expansion and Emergency Paid Sick Leave Form

The Leave of Absence Application is used by employees to request leave in accordance with the Families First Coronavirus Response Act. This application is in effect from April 1, 2020 to December 31, 2020.

## Employee Information

Name (Print): _____ Employee ID: _____

Business Email: _____ Personal Email: _____

Work #: _____ Cell / Home #: _____

Home Address: _____ City: _____ State: ____

Department: _____ Campus:_____

Supervisor's Name: _____ Supervisor's #_____

## Leave Request Type

**Leave Request Date:** From: _____ To: _____

**Emergency Family and Medical Leave Expansion Act (EFMLEA)**

☐ I am caring for a son or daughter under 18 years of age (or 18 years of age or older and incapable of self-care due to a mental or physical disability) of such employee if the school (elementary or secondary) or place of care of the son or daughter has been closed, or the child care provider of such son or daughter is unavailable due to COVID-19

☐Intermittent Leave **If Intermittent work schedule*, how often: _____Hour(s) per day _____ Hour(s) per week

**Emergency Paid Sick Leave Act (EPSLA)**

Is this a joint leave with a spouse who is also a UH employee: ☐Yes **or** ☐ No ***Time will be shared between both spouse****

Spouse Name: _____ **Employee ID:** _____

**This is a qualifying condition due to:** ** You can only select one qualifying condition**

☐ I am being subjected to a federal, state, or local quarantine or isolation order related to COVID-19

☐ I am being advised by a health care provider to self-quarantine due to COVID-19

☐ I am experiencing symptoms of COVID-19 and am seeking a medical diagnosis

☐ I am caring for an individual who is subject to an order under (a) above or being advised under (b) above

☐ I am caring for a son or daughter under 18 years of age (or 18 years of age or older and incapable of self-care due to a mental or physical disability) of such employee if the school (elementary or secondary) or place of care of the son or daughter has been closed, or the child care provider of such son or daughter is unavailable due to COVID-19

☐ I am experiencing other substantially similar condition specified by the Secretary of Health and Human Services in consultation with the Secretary of the Treasury and the Secretary of Labor.

☐Intermittent Leave **If Intermittent work schedule*, how often: _____Hour(s) per day _____ Hour(s) per week

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## Provisions

**** You must initial by each statement to denote you understand and agree to the following provision:**

**I understand and agree to the following provisions:**

_____ I understand I may be required to provide supporting documentation for the leave I'm requesting.

_____ I understand I am eligible for up to 12 weeks of FMLA and this leave may be taken intermittently.

_____ I understand, if applicable, depending on how much FMLA leave I have already taken, I may have already exhausted my FMLA leave for the period or may only be entitled to a portion of leave under this Act.

_____ I understand the first 10 days (two weeks) of FMLA are unpaid, but I may substitute and use emergency sick leave, my accrued sick leave, my accrued vacation leave, or Comp time at 1.5 or 1.0. during this period.

_____ I understand I can also use the paid sick leave under the Emergency Paid Sick Leave Act to cover these first 10 days. The remaining period of the 10 weeks is paid at 2/3 regular rate of pay but may be subject to federal limitations.

_____ I understand after 12 weeks or the amount of approved leave is exhausted I must notify my supervisor of my intent to return to work.

_____I understand I will be given state premium sharing toward the cost of health insurance while on FML. I will be billed (or the amount will be deducted from any sick leave or vacation pay) for additional premiums in excess of the state premium sharing. Should I fail to pay the additional premiums, the health coverage will be changed to the Employee Only level and optional coverages will be terminated. Continuation of group insurance is subject to the conditions and policies of ERS relating to coverage while on leave without pay.

**Employee Signature:** _____ **Date:** _____

**Make sure you complete and sign the application. You can submit the completed application by using one of the below options:**

1.Submit online through HR Portal

2. Fax to 713-743-4830