

SPOKANE COUNTY

HUMAN RESOURCES DEPARTMENT
824 N. ADAMS ST.
SPOKANE, WASHINGTON 99260
TELEPHONE – (509) 477-2127/FAX– (509) 477-6042

Emergency Family and Medical Leave Expansion (FFCRA)

Employee Name: _____ Last 4 SSN or Employee ID: _____
Department: _____ Job Title: _____
Date of Hire: _____ Scheduled Weekly Hours: _____
Requested Leave Start Date: _____ Estimated Leave End Date: _____
 Continuous Intermittent: (MUST BE TAKEN IN FULL DAYS ONLY) Anticipated Schedule: _____

Purpose of Emergency Family and Medical Leave Expansion: Effective April 1, 2020 and ending December 31, 2020, employees who have been employed by Spokane County for at least thirty (30) calendar days, are eligible for expanded FMLA leave **if work is available, but the employee is unable to work or telework due to the required care of the employee's child under eighteen (18) years of age as a result of school or childcare closure due to COVID-19.**

I attest I am caring for a minor child whose school or daycare is closed, or the child's care provider is unavailable because of COVID-19 and no other suitable person (generally defined as a co-parent, co-guardian, or usual child care provider) is available to care for the child(ren) during the period of requested leave. INITIAL HERE _____

MINOR CHILD'S FULL NAME

SCHOOL/DAYCARE NAME

Waiting Period: There is a ten (10) day unpaid waiting period before emergency FMLA expansion leave takes effect. During that waiting period, I am requesting to use leave as follows:

- Accrued paid leave - type: _____ dates: _____
type: _____ dates: _____
- Emergency Paid Sick Leave (up to 80 hours) * dates: _____
*Must complete the Emergency Paid Sick Leave form
- Unpaid leave dates: _____

In typing my initials below, I attest I have work available to perform, but I am unable to work or telework because of the reason indicated above. I understand this is a one-time benefit available 4/1/2020- 12/31/2020 and certify I have not previously utilized this leave (with my current or a previous employer). If it is later proven I falsified information, I may be disciplined and may be required to repay any compensation I received. I understand should I fail to return to work from my leave the county may require I repay any benefit premiums paid on my behalf while out on this leave. I understand this Expanded FMLA Leave is limited to a total of 12 weeks of leave. Documentation may be required to support this request.

EMPLOYEE INITIALS : _____ DATE: _____