City of Clearlake
14050 Olympic Drive, Clearlake, California 95422
(707) 994-8201 Fax (707) 995-2653
www.clearlake.ca.us

EMPLOYEE CERTIFICATION OF NEED FOR EMERGENCY FAMILY MEDICAL LEAVE

Print Name:_____ Date:_____

Department:_____ Supervisor: _____

Status: Regular Full Time_____ Regular Part Time_____ Temporary_____
_____

Hire Date: _____ Average Regular Work Schedule (circle): M T W TH F SA SU

Average hours scheduled per week: _____

Have you taken leave under FMLA in the past 12 months? Yes_____ No_____
If yes, how many days?_____

Compensation:
First 10 days of Leave is without pay unless the following is designated:
I wish to use the following leave during the first 10 days of EFMLEA:
Leave without pay_____ Sick_____
Vacation_____ Compensatory Time Off_____
Emergency Paid Sick Leave_____
If using Emergency Paid Sick Leave, also complete Certification of Need for Emergency Paid Sick Leave form

Pay as of the 11th day of Leave
Pay under EFMLEA is based on 2/3rds of your regular pay. You may elect to supplement with your own accrued leaves. Initial your election below.
I do not wish to supplement EFMLEA pay. _____
*I wish to supplement EFMLEA pay with my accrued leaves.*_____
To supplement with accrued leaves, enter hours on a Leave of Absence form under the appropriate type of leave (vacation, sick, compensatory time). Indicate that the hours are EFMLEA.

I, _____, certify that I have a child who is under the age of 18, whose school or place of care has been closed, or whose child care provider is unavailable due to a COVID–19 emergency declared by either a Federal, State, or local authority. Due to the need to care for my child, I am unable to work (or telework). I understand that if my childcare needs change, I must immediately inform my supervisor and the City and I may be directed to report back to work (or telework).

Request Leave Start Date_____Expected End Date:_____

Signature:_____ Date:_____

ASD Use
Approved_____ Denied (reason)_____
Process Notes