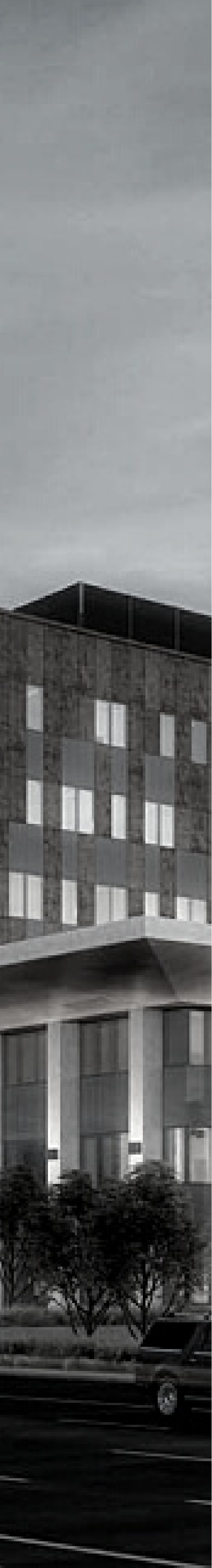

THE COUNTY OF HIDALGO

DEPARTMENT OF BUDGET & MANAGEMENT

Pay Requirements For The First Two Weeks (Select Only One Option)

__Emergency Paid Sick Leave at 2/3 Begin Date: ___________ End Date: ___________

__Accrued Leave (Excluding Sick Leave) Begin Date: ___________ End Date: ___________

__Leave without Pay Begin Date: ___________ End Date: ___________

Certification

I hereby certify, to the best of my knowledge, that the information provided is true and correct. I understand that false information may disqualify me from obtaining the expanded family and medical leave as provided by the Emergency FMLA Expansion Act and the FFCRA or may subject me to disciplinary or legal ramifications.

____________________________________ ____________________________________

Employee Signature Date

____________________________________ ____________________________________

Department Head Signature Date

Note: Please attach the schedule approved by Department Head along with this form.

FOR OFFICE USE ONLY

Received Date: _______________________

Processed Date: ______________________

Approved: ______ Denied: _______

Reason(s) for Denial:

____

____

____

Office Notes:

____

____

Received By: _________________________

Processed By: ________________________

Eligible for 12 Weeks: Yes: ____ No: ____

If prior FMLA has been taken, remaining balance: ______________________________

Exhausted FMLA: Yes: ____ No: ____

If employee exhausted FMLA prior to request, enter date exhausted: ____________