Request for Leave – Family First Coronavirus Response Act (FFCRA)

Employee Name: _____ **Office/Position:** _____

Duration Requested: Expected Start Date: _____ Expected End Date: _____

The Families First Coronavirus Response Act (FFCRA) requires certain employers to provide their employees with paid sick leave and expanded family and medical leave for specified reasons related to COVID-19. These provisions will apply from April 1, 2020 through December 31, 2020.

Entitlements:
Up to two weeks (80 hours) of paid sick leave based on the higher of their regular pay or paid at:

- *Qualifying Reasons #1-3* - 100% of paid sick leave for qualifying reasons #1-3 up to $511 daily;
- *Qualifying Reasons #4 & #6* - 2/3 for qualifying reason up to $200 daily;
- *Qualifying Reason #5* - Up to 12 weeks of paid leave and expanded family and medical leave paid at 2/3 for up to $200 daily.

Qualifying Reasons:
I am requesting to take leave related to COVID-19 due to my inability to work, including being unable to telework, because: (please choose one):

☐ #1. I am subject to federal, state or local quarantine order related to COVID-19.
- Name of governmental entity ordering quarantine:_____ *(Please provide documentation such as a notice that has been posted by government entity)*

☐ #2. I have been advised by a health care provider to self-quarantine due to concerns related to COVID-19.
- Name of Health Care Professional advising self-quarantine:_____
(Please provide documentation from Healthcare Professional)

☐ #3. I am experiencing symptoms of COVID -19 and am seeking medical diagnosis. *(Please provide documentation from medical provider)*

☐ #4. I am caring for an individual subject to an order described in (1) or self-quarantine as described in (2).
- Name of Subject: _____ Relationship of Subject:_____
(Please provide documentation from Healthcare Professional or government entity)

☐ #5. I am caring for my child whose school or place of care has been closed (or whose child care provider is unavailable) due to COVID-19 related reasons. *(Please provide documentation such as a notice that has been posted on a government school or day care website, or published in a newspaper, or an email from an employee or official of the school, place of care or child care provider)*

Name of Child(ren):_____ Age of Child(ren):_____

Child(ren) School/Day Care Provider(s):_____

___ *By checking here, I represent that no other person will be providing care for the child(ren) during the period for which I am receiving family medical leave. * If child(ren) is older than 14, please provide statement on why care is needed during daylight hours:* _____

☐ #6. I am experiencing any other substantially-similar condition specified by the Secretary of Health and Human Services, in consultation with the Secretaries of Labor and Treasury. *(Please provide documentation from Secretary of Health and Human Services)*

Additional Comments: _____
_____
_____

I hereby certify that the above listed information is true and correct.

Employee Signature: _____ Date of Request: _____

Approved by: _____ Date: _____