**Families First Coronavirus Response Act**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Employee Name (Last, First, MI) | | | | Phone Number | |
|  | | | |  | |
|  |  |  | |  |  |
| Date of Hire | Job Title | Department | | Supervisor Name | Average Hours/Week |
|  |  |  | |  |  |
|  |  |  | |  |  |
| I request leave beginning on (date): | | | My expected return date is: | | |
|  | | |  | | |

## Emergency Paid Sick Leave

### Check here to submit a request for *Emergency Paid Sick Leave.*

|  |  |  |  |
| --- | --- | --- | --- |
| **Select one or more of the following reasons for why you are unable to work, including telework:** | | | |
|  | 1. | I am subject to federal, state, or local quarantine or isolation order related to COVID–19. | |
|  |  | Name of governmental entity ordering quarantine: | |
|  | 2. | I have been advised by a health care provider to self-quarantine due to concerns related to COVID–19. | |
|  |  | Name of the health care professional advising self-quarantine: | |
|  | 3. | I am:  a.Requesting paid time off because I am experiencing symptoms of COVID-19 and seeking a medical diagnosis.  b. Requesting paid time off to receive the COVID-19 vaccine  c. Requesting paid time off to recover from symptoms associated with receiving the COVID-19 vaccine. | |
|  | 4. | I am caring for an individual who is subject to either number 1 or 2 above\*. | |
|  |  | Name and relationship to employee: | |
|  |  | Name of governmental entity ordering quarantine or health care professional advising self-quarantine: | |
|  | 5. | I am caring for a child due to a school or place of closure, or the childcare provider of the child is unavailable, due to COVID–19. I certify that no other person will be providing care for the child during the period for which I am receiving paid leave.  ***Select if applicable***: Special circumstances exist that require that I provide care for a child older than fourteen during daylight hours. | |
|  |  | Name and Age of Child: | Name of School / Place of Care that is Closed: |
|  |  | Name and Age of Child: | Name of School / Place of Care that is Closed: |
|  |  | Name and Age of Child: | Name of School / Place of Care that is Closed: |
|  | 6. | I am experiencing any 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. | |

## Paid Family and Medical Leave

### Check here to submit a request for *Paid Family and Medical Leave.*

|  |  |
| --- | --- |
| **An employee may be eligible to receive both Emergency Paid Sick Leave and Paid Family and Medical Leave.** | |
| I am unable to work, or telework, in order to care for a child because their school or place of care has been closed or their childcare provider is otherwise unavailable to provide care due to COVID-19. I certify that no other person will be providing care for the child during the period for which I am receiving paid leave.  ***Select if applicable***: Special circumstances exist that require that I provide care for a child older than fourteen during daylight hours. | |
| Name and Age of Child: | Name of School / Place of Care that is Closed: |
| Name and Age of Child: | Name of School / Place of Care that is Closed: |
| Name and Age of Child: | Name of School / Place of Care that is Closed: |

## Use of Other Paid Time Off

Please select available paid leave to use during the first 10 days of leave:

|  |  |
| --- | --- |
|  | Emergency Paid Sick Leave |
|  | Company-provided Sick/Personal Time Off |
|  | Company-provided Vacation Time Off |
|  | No Paid Time Off Available |

|  |  |
| --- | --- |
| **Employee Signature** | **Date** |
|  |  |

I certify that I am requesting leave for a covered reason under the Families First Coronavirus Response Act (FFCRA) and will provide additional documentation to support this leave, if requested by my employer. I acknowledge that I am subject to discipline, up to and including termination of employment, for falsifying my need for paid leave under the FFCRA.

## Eligibility – For Office Use Only

YES NO

|  |  |  |
| --- | --- | --- |
|  |  | Company Size – Under 500 Employees |
|  |  | Active Employee (who is unable to telework) |
|  |  | Employed for at Least 30 Days for Emergency Family Medical Leave |
|  |  | Request Approved |