**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.*

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| **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.*

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| **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 |