**Request for Leave under Families First Coronavirus Response Act**

Employees requesting Emergency Paid Sick Leave (EPSL) and/or Emergency Paid Family Medical Leave (EPFML) pursuant to the Families First Coronavirus Response Act must complete this form. You must provide as much advance notice as is reasonably practicable. Upon completion of this form, submit it to Human Resources for review and processing.

|  |
| --- |
| **Employee Name:** |
| **Employee Home Address:****E-mail:** |
| **Home Phone Number:****Cell Phone Number:** |
| **This is a** *(choose one)***:**  New request for leave  Request for an extension of leave |
| **Anticipated Begin Date of Leave:** **Expected Return to Work Date:** |

Type of Leave **Requested:**

**Emergency Paid Sick Leave** (up to 80 hours for full time employees and avg. two weeks for part time employees)

**Reason for Leave** (*check all applicable*) I am unable to work (or telework) for the following reasons:

I am subject to state, federal or local quarantine or isolation order related to COVID-19

**Name of government entity requiring your personal quarantine or isolation**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I have been advised by a health care professional to self-quarantine due to concerns related to COVID-19

**Name of health care professional advising you to self-quarantine**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I have symptoms related to COVID-19 and I am seeking a diagnosis

I am caring for an individual who is subject to quarantine or has been advised to quarantine related to COVID-19

**Name of person being cared for and relation to employee**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I need to care for my child under age 18 because the child’s school, child care or child care provider is closed or unavailable because of COVID-19

I am experiencing other conditions substantially similar to COVID-19 as specified by HHS.

**Emergency Family Medical Leave** (up to 12 weeks of paid leave at 2/3 regular rate for the below reason)

I need to care for my child under age 18 because the child’s school, child care or child care provider is closed or unavailable because of COVID-19.

**Continued on Page Two**

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**IF EITHER OR BOTH OF THE ABOVE REQUESTED LEAVES ARE TO TAKE CARE OF A CHILD DURING SCHOOL/CHILD CARE CLOSURE OR UNAVAILABILITY**

**Name of School or Child Care Provider that is closed or unavailable**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Name and age of each child to be cared for:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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I hereby represent and certify that no other person will be providing care for the child during the period for which I will be receiving family medical leave.

If I will only be taking care of a child over fourteen (14) years of age during daylight hours, I hereby certify that the following special circumstances exist**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**If you are able to work intermittently during this time** (if requested to by employer), please describe when you would be available for work, if needed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**I certify that the above information is accurate and complete and that I am unable to work or telework for these reasons. I understand that if I fail to report for work on or before the scheduled return date indicated above or fail to contact Management/Human Resources regarding my absence from work beyond such scheduled date of return, my employment may not be protected by law.**

**Employee Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*PROOF PROVIDED BY EMPLOYEE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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EMPLOYER SHOULD RETAIN THIS FORM AND ACCOMPANYING DOCUMENTS FOR FOUR YEARS