FFCRA LEAVE REQUEST FORM

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.

Paid Leave Entitlements

Generally, employers covered under the FFCRA must provide employees up to two weeks (80 hours or a part-time employee's two-week equivalent) of paid sick leave based on the higher of their regular rate of pay, or the applicable state or Federal minimum wage, paid at:

• 100% for qualifying reasons #1 through #3 below, up to $511 daily and $5,110 total;
• 2/3 for qualifying reasons #4 and #6 below, up to $200 daily and $2,000 total; and
• Up to 12 weeks of paid sick leave and expanded family and medical leave paid at 2/3 for qualifying reason #5 below for up to $200 daily and $12,000 total.

Requestor Information:

Employee Name: _____ **Employee ID**: _____

Cell Phone #: _____ **Email Address**: _____

Supervisor Name: _____ **Department**: _____

Date of leave to begin: _____ **Date of leave expected to end: _____**

Average number of hours you normally work within a two-week period: _____

An employee is entitled to take paid sick leave specified under the FFCRA if the employee is unable to work, including telework (work remotely), because the employee:

1. **Is subject to a Federal, State, or local quarantine or isolation order related to the COVID-19**;
   - Please provide the name of the agency that issued the order:_____
2. **Has been advised by a health care provider to self-quarantine related to COVID-19;**
   - Please provide the name of the health care who advised you of this action: _____
3. **Is experiencing COVID-19 symptoms and is seeking a medical diagnosis;**
   - Note: If your reason for leave is due to your own serious health condition related to COVID-19 or to care for your spouse, son, daughter, or parent with a serious health condition related to COVID-19, then the normal FMLA certification requirements still apply and regular FMLA forms will be used.
4. **Is caring for an individual subject to an order described in #1 or self-quarantine described in #2;**
   - Please provide agency name or health care provider that issued the order to the person that you are providing care for: _____
5. **Is caring for his or her child whose school or place of care is closed (or childcare provider is unavailable) due to COVID-19 related reasons;** or
   - Please provide name of child and name of school or childcare provider which is now closed or become unavailable: _____
   - Do you represent that no suitable person will be caring for the son or daughter during the period for which you are taking paid sick leave and/or expanded family medical leave? Yes or No
6. **Is experiencing any other substantially similar condition specified by the US Department of Health and Human Services.**

Please specify which reason above is most closely related to your need to request FFCRA Leave: _____

I certify that the above information is true and correct to the best of my knowledge. I also certify that I am unable to work or telework because of one of the reasons above.

Employee signature: _____ Date: _____

(Original form is maintained by the HR Office. Copies only allowed for Employee and Supervisor.)

Revised 4/3/2020