Families First Coronavirus Response Act - Emergency Paid Sick Leave Act
Employee Leave Request Form

Name: ______________________________ Date of Request: ______________________

Title and Building: ____

Date(s) FFCRA Leave Requested: *From* ______________________ *To* ______________________

I am requesting a leave of absence under the Emergency Paid Sick Leave Act (EPSLA) because I am unable to work or telework for the following reason *(please check appropriate reason and provide required information)*:

☐ (1) I am subject to a federal, state, or local quarantine or isolation order related to COVID-19.
Governmental entity ordering quarantine or isolation: ______________________________

☐ (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 provider: ______________________________

☐ (3) I am experiencing COVID-19 symptoms and am seeking a medical diagnosis. **Leave is limited to the time you are taking affirmative steps to obtain a medical diagnosis (i.e., time spent making, waiting, or attending an appointment related to COVID-19).*

☐ (4) I am caring for an individual subject to an order described in (1) or self-quarantined as described in (2).
Name of individual and relationship to employee: ______________________________
Governmental entity ordering quarantine or isolation: ______________________________ *OR*
Name of the health care provider: ______________________________

☐ (5) I am caring for my child whose school or place of care is closed or whose childcare provider is unavailable due to COVID-19 related reasons (*for leave beyond 2 weeks, please refer to the Expanded FMLA Under FFCRA Request Form*).
Name(s) and age(s) of children: ______________________________
☐ *(Check if applicable) My child is 15 years or older, and I certify that the following are the special circumstances that exist that require me to provide care for my child*: ______________________________
____
Name of school and/or place of care: ______________________________
**I certify that no other suitable person is available to care for the child during this period*: ☐ Yes ☐ No
**I am requesting to take leave as follows (subject to the District's approval)*: ☐ Continuous Leave ☐ Intermittent Leave
(Complete if appliable) I am requesting the following intermittent leave schedule (subject to the District's approval):

	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
Days/Time I Can Work					
Days/Time I Require Leave					

☐ (6) I am experiencing any other substantially similar condition specified by the Secretary of Health and Human Services in consultation with the Secretary of Treasury and the Secretary of Labor.

Paid Leave: I understand that, consistent with the EPSLA, if I am taking leave for reasons (1)-(3) outlined above, I am eligible for 100% of my regular pay (up to maximum weekly/total amounts) for up to two weeks (80 hours); and if I am taking leave for reasons (4)-(6) outlined above, I am eligible for 2/3 of my regular pay (up to maximum weekly/total amounts) for up to two weeks (80 hours).

☐ (*Check if applicable*) I am requesting to *supplement* any EPSLA leave I am granted with my accrued paid leave that I would otherwise be able to use, so that my pay is equal to 100% of my regular pay. I understand that I must still qualify for use of any paid leave pursuant to the applicable policies, procedures, collective bargaining agreements, handbook provisions, etc.

I hereby certify that I am unable to work or telework because of the qualified reason stated above. I understand that, if my need for leave outlined above changes, I must contact my supervisor immediately. I understand that I must inform my supervisor of my plans to return to work and may, as appropriate, be required to provide a fitness for duty certificate prior to returning to work. **I certify that all statements made in this Request Form are true and accurate and understand that my employer is relying on my representations and that false representations may result in disciplinary action up to an including termination**.

Employee Signature: ______________________________ Date: ______________________