**Families First Coronavirus Response Act (FFCRA) Leave Request Form**

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| **Employee Name** |  | | |
| **Job Title** |  | **Date of Hire** |  |
| **Full-time / Part-time** |  | **Part-time schedule** |  |

**Sick Leave:** Employees are eligible for this sick leave entitlement between April 1, 2021 and September 30, 2021. Full-time employees are eligible for 80 hours of sick leave, and part-time employees are eligible for the number of hours of leave that the employee works on average over a two-week period.

**Start Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ End Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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| **Qualifying Reasons:** **Please check the box next to the reason you are requesting sick leave and provide documentation to support your request.** |
| **1. is subject to a Federal, State, or local quarantine or isolation order related to COVID- 19;**  Government Entity that issued the quarantine or isolation order: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **2. has been advised by a health care provider to self-quarantine related to COVID-19;**  Name of health care provider advising self-quarantine:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **3. is experiencing COVID-19 symptoms and is seeking a medical diagnosis;** |
| **4. is caring for an individual subject to an order described in (1) or self-quarantine as described in (2);**  Name of individual being cared for: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Relationship to individual being cared for: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Name of Healthcare Provider advising self-quarantine: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_    Government Entity that issued the quarantine or isolation order: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **5. is caring for a child whose school or place of care is closed (or childcare provider is unavailable) for reasons related to COVID-19;**   |  |  |  | | --- | --- | --- | | **Child’s name** | **Age** | **School or Care Provider Name** | |  |  |  | |  |  |  | |  |  |  | |  |  |  | |  |  |  |   If your leave request is to care for a child older than fourteen (14) due to special circumstances please initial below:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Initial |
| **6.** **is experiencing any other substantially similar condition specified by the Secretary of Health and Human Services, in consultation with the Secretaries of Labor and Treasury.** |
| **7. Receiving a COVID-19 vaccine** |
| **8. Recovering from an injury, illness, disability or condition related to obtaining the vaccine** |
| **9. Seeking or awaiting COVID-19 test results or a medical diagnosis for COVID-19 or employer has requested a test or diagnosis** |
| **FMLA Leave**  In addition to the paid sick leave referenced above, employees who have been employed for at least 30 calendar days may be eligible for up to 12 weeks of **paid** family leave, FMLA, for any of the reasons related to COVID-19 as outlined above.  The total amount of FMLA an employee is entitled to may not exceed 12 weeks in a 12-month period.  The 12 weeks of FMLA are paid at 2/3 the employee’s regular rate or 2/3 the minimum wage, whichever is higher.  This FMLA leave entitlement is available between April 1, 2021 and September 30, 2021.  Please note that while this is a Federal FMLA entitlement, individual state mandates may also cover your absence and you will receive a designation notice detailing all applicable leave entitlements.  **Please check this box if you are also requesting FMLA leave:**  FMLA Start Date: **: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** FMLA End Date: **: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Reason for FMLA request:**  1. is subject to a Federal, State, or local quarantine or isolation order related to COVID- 19;  2. has been advised by a health care provider to self-quarantine related to COVID-19;  3. is experiencing COVID-19 symptoms and is seeking a medical diagnosis;  4. is caring for an individual subject to an order described in (1) or self-quarantine as described in (2);  5. is caring for a child whose school or place of care is closed (or childcare provider is unavailable) for reasons related to COVID-19;  6. is experiencing any other substantially similar condition specified by the Secretary of Health and Human Services, in consultation with the Secretaries of Labor and Treasury.  7. Receiving a COVID-19 vaccine  8. Recovering from an injury, illness, disability or condition related to obtaining the vaccine  9. Seeking or awaiting COVID-19 test results or a medical diagnosis for COVID-19 or employer has requested a test or diagnosis  Intermittent Leave (remove if covered by OFLA: please note that intermittent leave may not be available in all circumstances and will be considered on a case by case basis). Please detail your intermittent leave request below.  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  I understand that this will be counted as FMLA leave and will reduce the 12 weeks of FMLA leave otherwise available under the FMLA policy. |
| **Sick Leave Rate of Pay:** Reasons 1 – 3 and 7 – 9 will be paid at the employee’s regular rate or the applicable minimum wage (whichever is higher) and reasons 4 – 6 are paid at 2/3 the employee’s regular rate or 2/3 the applicable minimum wage (whichever is higher). Daily and aggregate maximums apply. |
| **FMLA Leave Rate of Pay:** FFCRA FMLA leave will be paidat 2/3 the employee’s regular rate or 2/3 the applicable minimum wage (whichever is higher). Daily and aggregate maximums apply. |

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| **PTO Request (if applicable)** | |
| **Would you like to use available paid leave benefits to supplement FFCRA sick leave for reasons 4, 5, or 6 or for any FFCRA FMLA leave (reasons 1-9)?** | **Yes**  **No** |
| **Notes:** | |

**By signing below, I confirm that I am unable to work or telework due to the reason selected above. Additionally, if the reason for leave selected is for childcare, I confirm that no other person will be providing care for my child(ren) during the period for which I am receiving family medical leave.**

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