**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