

## FFCRA LEAVE OF ABSENCE REQUEST

<b>Name</b>	<b>Date</b>
<b>Job Title</b>	<b>Department/Supervisor</b>

**TO BE COMPLETED BY EMPLOYEE:**

**A. I request a paid leave of absence under the Emergency Paid Sick Leave Act from \_\_\_\_\_ to \_\_\_\_\_ (insert dates). I am unable to work or telework because:**

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 health care provider: \_\_\_\_\_
3. I am experiencing symptoms of COVID-19 and am seeking a medical diagnosis.
4. I am caring for an individual who is subject to a Federal, State, or local quarantine or isolation order related to COVID-19 or who has been advised by a health care provider to self-quarantine due to concerns related to COVID-19.  
Name of individual and relationship to employee: \_\_\_\_\_  
Governmental entity ordering quarantine or isolation: \_\_\_\_\_
5. I am caring for my son or daughter because my child's school or place of care has been closed, or the child care provider of my child is unavailable, due to COVID-19 precautions.  
Name(s) and age(s) of child(ren): \_\_\_\_\_  
Name of school and/or place of care: \_\_\_\_\_
6. I am experiencing any other substantially similar condition specified by the Secretary of Health and Human Services in consultation with the Secretary of the Treasury and the Secretary of Labor.

**B. I request approval for a paid leave of absence under the Emergency Family and Medical Leave Expansion Act from \_\_\_\_\_ to \_\_\_\_\_ (insert dates) because:**

5. I am caring for my son or daughter because my child's school or place of care has been closed, or the child care provider of my child is unavailable, due to COVID-19 precautions.

**LEAVES OTHER THAN THE ABOVE ARE NOT FFCRA ELIGIBLE**

**I understand that I can use my accrued sick and/or vacation time to off set the difference in pay for reasons 4, 5, and 6. Please circle yes or no; Employee will use sick and/or vacation - yes or no (circle one).**

**I understand that prior to any leave, I must make arrangements to continue insurance coverage if I am eligible. Further, I understand that I must contact HR and/or my supervisor before I can return to work.**

Employee  
Signature \_\_\_\_\_ Date \_\_\_\_\_

❖ Completed form will be maintained in a confidential file, separate from your personnel file.

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## C. Other information

If your leave is intermittent, please describe the nature of your intermittent leave:

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If your child 15 years of age or older, please describe the special circumstances that exist requiring you to provide care:

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**If I am requesting leave because I am unable to work or telework due to the fact my child(ren)'s school or place of care has been closed due to COVID-19 reasons, by signing below I attest that special circumstances exist that require me to provide care and no other person will be providing care to the child during the period in which I receive family medical leave.**

Employee

Signature \_\_\_\_\_ Date \_\_\_\_\_

### TO BE COMPLETED BY HUMAN RESOURCES:

#### Notes

(job restoration, maximum length, insurance, benefit accrual, service, review date, etc.)

Human Resources-Benefits Manager's Signature:

Eligible \_\_\_\_\_ Date \_\_\_\_\_

Ineligible \_\_\_\_\_ Date \_\_\_\_\_