

**Employee Request Form For
EMERGENCY PAID SICK LEAVE**
Under The Families First Coronavirus Response Act (FFCRA)
Available to eligible employees April 1- December 31, 2020

EMPLOYEE REQUEST FOR EMERGENCY PAID SICK LEAVE

Employees requesting Emergency Paid Sick Leave pursuant to the FFCRA (Families First Coronavirus Response Act) must complete this form. To be eligible, employees must be unable to work remotely (telecommute/telework), as certified by the employer. Eligible employees are entitled to up to eighty (80) hours of paid sick leave pursuant to this policy.

Employee Name:	Employee Job Title:
Employee Home Address:	
Employee Telephone Number:	E-mail:
<input type="checkbox"/> Request for Leave	<input type="checkbox"/> Request for Extension of Leave
Date of Requested Leave:	Date of Anticipated Return to Work:

Reason for Requesting Leave (check applicable reason): I hereby certify that I am unable to work (or telework), due to a need for leave for the following COVID-19 reasons:

1. I am subject to a federal, state, or local quarantine or isolation due to concerns related to COVID-19;
2. I have been advised by a healthcare provider to self-quarantine due to concerns related to COVID-19;
3. I am experiencing symptoms consistent with COVID-19 and is seeking a medical diagnosis;
4. I am caring for an individual who is either under a federal, state, or local quarantine order due to concerns related to COVID-19 or has been advised by a healthcare provider to self-quarantine due to concerns related to COVID-19 (at two-thirds the regular rate of pay);
5. I am caring for his/her child due to the closure of a school or childcare provider due to COVID-19 precautions (at two-thirds the regular rate of pay); or
6. I am experiencing any substantially similar condition as specified by the Secretary of the Department of Health and Human Services (at two-thirds the regular rate of pay).
7. I am sick and unable to perform my regular job duties, and I **DO NOT** meet any of the conditions set forth in 1-6 above. I expect to return to work on _____. (You are eligible to use your accrued paid leave time off)
8. I **DO NOT** meet any of the requirements above, but would like to take a leave of absence from work until _____ because I do not feel safe at work because of the COVID-19 virus. I would like to use my available accrued paid leave time, and then go on an unpaid leave of absence once my available paid leave is exhausted.

NOTE:

- For qualifying reasons 1-3 above, FFCRA Emergency Paid Sick Leave is paid at 100% of your regular rate of pay, capped at \$511.00 per day, for a maximum benefit total of \$5110.00, without using your accruals.
- For qualifying reasons 4-6 above, FFCRA Emergency Paid Sick Leave is paid at 66.67% of your regular rate of pay, capped at \$200.00 per day, for a maximum benefit total of \$2000.00, without using your accruals.

Type of Leave Requested : Continuous Leave **or** Intermittent Leave

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

Supplement Accrued Time: For employees whose leave request is based on numbers 4-6 above, the leave is at 2/3 of your regular rate of pay, up to the capped per day, and total limits referenced above. In this case, you may supplement your paid leave with accrued time to cover the remaining 1/3 pay. You are not required to supplement. If you would like to utilize existing accrued time to cover the remaining 1/3 of your pay, please indicate accordingly below.

Vacation/PTO (____ Hrs.) Sick leave (____ Hrs.) Personal (____ Hrs.) Other (____ Hrs.)

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Employee Certification and Signature: *I certify that the above information is accurate. I understand that if I fail to report for work on or before the scheduled return date indicated above or fail to contact Human Resources regarding my absence from work beyond such scheduled date of return, my employer may take corrective action up to and including possible termination of my employment.*

I certify that I am unable to work remotely (telecommute/telework), subject to certification by the employer.

I understand that I am responsible for immediately informing my employer of any changes in my status as indicated above.

Employee Signature: _____ Date: _____

To be completed by Human Resources:

HR Signature: _____ Date: _____ Approved Not approved

Effective Date _____ Pay Code _____ Employee Rate of Pay: _____

To be completed by Human Resources:

HR Signature: _____ Date: _____ Approved Not approved

Effective Date _____ Pay Code _____ Employee Rate of Pay: _____

HR Certification: The employee is not able to work remotely, or is able to work remotely. If the employee is able to work remotely, the employee is able to work full-time, or part-time for _____ hours per _____.

For Qualifying Reasons 4-6 Above – Employee Has Elected to supplement with Accrued Paid Leave:
 Vacation/PTO (____ Hrs.) Sick leave (____ Hrs.) Personal (____ Hrs.) Other (____ Hrs.)

Additional Comments (HR, Payroll):