Families First Coronavirus Response Act Request Form

The Families First Coronavirus Response Act (the "FFCRA"), effective April 1, 2020, provides State employees with additional emergency paid sick leave and expanded family and medical leave for specified reasons related to COVID-19. These provisions apply to leave taken between April 1, 2020 and December 31, 2020.

Emergency Paid Sick Leave: Full time eligible employees in a 40 hour work week may discharge up to eighty (80) hours of emergency paid sick leave, at the employee's regular rate of pay (part-time employees may discharge sick leave in an amount equal to the number of hours that he or she works, on average, over a two (2) week period – this includes employees who are scheduled to work 35 hour per week as they are considered to be part-time under the FFCRA) **if the employee is unable to work, or telework**, due to a reason listed below.

Emergency Family and Medical Leave Act Expansion: Employees who have been employed for at least thirty (30) days prior to their leave request, may be eligible for up to two (2) weeks of unpaid and ten (10) weeks of partially paid expanded family and medical leave where an employee is unable to work or telework under the State's Teleworking Policy due to a bona fide need for leave to care for the employee's child if the child's school or place of care has been closed, or the child care provider of such child is unavailable, due to a public health emergency declared by a Federal, State or local authority as a result of COVID-19.

Employee Name: _____   Title: _____

Department: _____   Division: _____

Date of Hire:_____

Date(s) for which leave is requested: _____To_____

Are you requesting intermittent leave?   Yes _____ No _____. If yes, please explain: _____
_____

If approved for telework, please provide the reason you are unable to telework due to a need for leave because of COVID-19 related reasons:
_____
_____
_____

Qualifying COVID-19 reasons for leave. Please check the reason you are requesting leave and provide the required documentation:

_____ (1) I am subject to a Federal, State or local quarantine or isolation order related to COVID-19

- **Required Documentation**: A copy of the Quarantine or Isolation Order

_____ (2) I have been advised by a health care provider to self-quarantine due to concerns related to COVID-19

- **Required Documentation**: Written documentation from the health care provider who advised you to self-quarantine for COVID-19 related reasons.

_____ (3) I am experiencing symptoms of COVID-19 and am seeking a medical diagnosis

- **Required Documentation**: Written documentation from the health care provider that you are experiencing symptoms of COVID-19 and are seeking a medical diagnosis.

_____ (4) I am caring for an individual who (a) is subject to a Federal, State or local quarantine   or isolation order or (b) has been advised by a health care provider to self-quarantine due to concerns related to COVID-19.

- **Required Documentation:** (a) a copy of the quarantine or isolation order; or (b) written documentation from the health care provider who advised the individual being cared for to self-quarantine due to COVID-19 reasons.
- Name of individual being cared for: _____
- Relationship to individual being cared for: _____

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

- **Required Documentation:**
- (a) Notice of closure or unavailability from child(ren)'s school, place of care, or child care provider, including a notice that may have been posted on a government, school or day care website, published in a newspaper, or emailed to you from an employee or official of the school, place of care, or child care provider.

- (b) the name(s) of child(ren) being cared for:
  _____

- (c) Statement representing that no other suitable person is available to care for the child(ren) during the period of requested leave.
  _____
  _____

☐   I elect to use accrued paid leave to supplement pay under emergency paid sick leave pursuant to reason 4 or 5 above, so that I receive the full amount of my bi-weekly wages.

Type of accrued leave to be used: _____

_____

Signature of employee requesting leave: _____

Telephone Number: _____Email Address: _____

Supervisor's name: _____Date: _____