FFCRA Paid Leave Request

Employees requesting Emergency Paid Sick Leave (EPSL) or Emergency FMLA (EFMLA) pursuant to the Families First Coronavirus Response Act (FFCRA) must complete this form. There are strict rules that govern when these new forms of paid leave may be used and failure to provide adequate information may result in a denial of benefits. You must provide as much advance notice as is reasonably practicable.

Employee Name: _____ Employee ID Number: _____

E-mail Address: _____Phone Number: _____

Department: _____Shift: _____

Leave Start Date: _____Expected Return Date: _____

Reason for Leave: I am unable to work (or telework) for the following reason(s):

☐ 1. I am subject to a Federal, State, or local quarantine or isolation order related to COVID-19 (must take full two weeks EPSL unless teleworking).

Name of agency or official ordering quarantine: _____

☐ 2. I have been advised by a healthcare provider to self-quarantine related to COVID-19 (must take full two weeks EPSL unless teleworking).

Name of healthcare provider: _____

Phone number of healthcare provider: _____

☐ 3. I am experiencing COVID-19 symptoms and I am seeking a medical diagnosis (must take full two weeks EPSL unless teleworking).

Name of healthcare provider: _____

Phone number of healthcare provider: _____

☐ 4. I am caring for an individual subject to an order from a government agency or official or healthcare provider to self-quarantine (must take full two weeks EPSL unless teleworking).

Name of individual I am caring for: _____

My relationship to the individual: _____

Name of agency, official or healthcare provider: _____

Phone number of healthcare provider if applicable: _____

☐ 5. I am caring for a child (under age 18 or incapable of "self-care" as defined under FMLA) whose school or place of care is closed (or childcare provider is unavailable) for reasons related to COVID-19 (may take EPSL or EFMLA intermittently).

Name of child(ren) I am caring for: _____

My relationship to the child(ren): _____

Name of school or childcare provider: _____

Phone number of school or childcare provider: _____

If applicable, describe the nature of the condition that makes your adult child incapable of self-care:

_____

☐ I certify that no other suitable person will be caring for my son or daughter during the period for which I am taking EPSL or EFMLA.

☐ 6. I am experiencing any other substantially-similar condition specified by the Secretary of Health and Human Services, in consultation with the Secretaries of Labor and Treasury (must take full two weeks EPSL unless teleworking).

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

_____

_____

_____

EPSL leave is paid at the employees' regular rate of pay for up to 80 hours (or a prorated amount for part time employees) for reasons 1 – 3 up to $511 per day. EPSL is paid at 2/3 the employees' regular rate of pay for up to 80 hours (or a prorated amount for part time employees) up to $200 per day for reasons 4 - 6.

Substitution of Paid Leave: The first 10 days of your leave under EFMLA is unpaid, however you may use any EPSL or other paid leave available to you during that time. Please indicate if you would like to use paid leave

Leave	Number of Hours
EPSL ☐	
Vacation ☐	
Sick Leave ☐	

I certify that the above information is accurate and complete. I understand that false information may lead to denial of benefits and or disciplinary action.

I also understand that if I fail to report for work on or before the scheduled return date or fail to contact Human Resources to extend my absence, I may be subject to disciplinary action.

_____ _____

Employee Signature Date