FFCRA LEAVE OF ABSENCE: EMPLOYER APPROVAL FORM

Name	**Date**
Job Title	**Department**

A. Your request for a paid leave of absence under the Emergency Paid Sick Leave Act (EPSL) has been approved for the following reason:

☐ 1. You are subject to a federal, state, or local quarantine or isolation order related to COVID–19.

☐ 2. You have been advised by a health care provider to self-quarantine due to concerns related to COVID-19.

☐ 3. You are experiencing symptoms of COVID-19 and am seeking a medical diagnosis.

☐ 4. You are 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.

☐ 5. You are caring for a son or daughter because your child's school or place of care has been closed, or the child care provider of your child is unavailable, due to COVID–19 precautions.

B. Your request for a paid leave of absence under the Emergency Family and Medical Leave Expansion Act (EFMLEA) has been approved because:

☐ You are unable to work or telework due to a need to care for your son or daughter because your child's school or place of care has been closed, or the child care provider of your child is unavailable, due to COVID–19 precautions.

C. Dates and Frequency of Leave:

Beginning date of leave: _____ Expected return to work date: _____

Amount of of leave available: ☐ EPSL up to _____ hrs ☐ EFMLA up to _____ weeks

Frequency: ☐ Continuous leave ☐ Your request for intermittent leave is approved as follows:

Days	**MONDAY**	**TUESDAY**	**WEDNESDAY**	**THURSDAY**	**FRIDAY**	**SATURDAY**	**SUNDAY**
Time of Work							
Time of Intermittent Leave							

Form provided by Employers Council
Contact Bob Coursey, Esq., SPHR, SHRM-SCP with questions
bcoursey@employerscouncil.org / 801.364.8479

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D. Substitution of Paid Leave for Unpaid EFMLEA Leave: For the first 10 days of EFMLA leave, you elected to utilize: ☐ **[PTO/Vacation]**[1] _____ hrs ☐ EPSL _____ hrs

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E. [OPTIONAL – SEE FOOTNOTE 2 below[2]] Supplementation of EPSL or EFMLEA Leave: Your request to supplement EPSL or EFMLA is approved as follows:

☐ **[PTO/Vacation]** You currently have _____ hours of this leave available to use. Employer agrees that you can use _____ hours per **[day/week]** of this leave to supplement your EPSL or EFMLEA, up to the maximum of your regular wage.

☐ **[Sick]** You currently have _____ hours of this leave available to use. Employer agrees that you can use _____ hours per **[day/week]** of this leave to supplement your EPSL OR EFMLEA, up to the maximum of your regular wage.

Other information regarding the voluntary agreement between us to supplement EPSL and/or EFMLEA with available paid leave:

_____

_____

_____

_____

F. Fitness for Duty Certification: If you have taken leave for a reason related to you personally having symptoms of COVID-19 or having COVID-19, you must provide a fitness-for-duty certification to be restored to employment. If certification is not timely received, your return to work may be delayed until certification is provided.

By signing below I indicate that I am in agreement with the information on this FFCRA Leave of Absence Approval form.

Employee Signature _____ Date_____

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

[1] EMPLOYERS: Highlights note areas you should insert applicable information.
[2] EMPLOYERS: You do not have to agree to allow employees to supplement their EPSL and EFMLA leave. Section E is optional.