

FFCRA LEAVE OF ABSENCE: EMPLOYEE REQUEST FORM

Name	Date
Job Title	Department

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: _____ **OR**
Name of health care provider: _____
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.

Intermittent Leave: If you are reporting to the workplace to work, you can request intermittent leave for reason A5. If you are teleworking, you can request intermittent leave for reasons A1-6. Your request is subject to our mutual agreement.

I request (choose one): continuous leave intermittent leave

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

- I am unable to work or telework due to a need to care 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: _____

Intermittent Leave: You can request intermittent leave for reason B. Your request is subject to our mutual agreement.

I request (choose one): continuous leave intermittent leave



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Substitution of Paid Leave: Pursuant to the FFCRA, the first 10 days of your leave is unpaid. However, you may be eligible to utilize emergency paid sick leave (EPSL) provided under the FFCRA. You may also choose to utilize any available **[paid time off/vacation]**¹. Please indicate below what paid leave, if any, you wish to utilize during your Emergency Family and Medical Leave (EFMLA):

[PTO/Vacation] _____ hrs
 EPSL _____ hrs
 I do not wish to use paid leave

C. Other information

If you requested intermittent leave above, please describe the nature of your intermittent leave (what days of the week you will need intermittent leave, what times of the day you can work on those days, and what times of the day you need intermittent leave on those days):

Days	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY
Time(s) Can Work							
Time(s) Request Intermittent Leave							

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

[OPTIONAL – SEE FOOTNOTE 2 BELOW²] You may request to supplement your EPSL or EFMLA with accrued paid leave that would otherwise be available for you to use under our **[Paid Time Off/Vacation/Sick] polic[y/ies]** for the purpose you identified above. **For example, if you request EFMLA (in B above), you could likely use your accrued [PTO / vacation] to supplement your EFMLA, but you could not use your accrued sick leave – because no one is sick.** Your request is subject to our mutual agreement and would supplement your EPSL or EFMLA up to the maximum amount of your normal pay.

I request to supplement my EPSL/EFMLA leave with the following accrued paid leave:

[PTO/Vacation]
 [Sick Leave] (limited to situations where you could otherwise take sick leave)

LEAVES OTHER THAN THOSE MENTIONED IN THIS FORM ARE NOT FFCRA ELIGIBLE

I understand that prior to any leave, I must make arrangements to continue insurance coverage if I am eligible. If my need for leave changes, including my inability to return to work as scheduled, I understand that I must contact HR and/or my supervisor immediately. Further, I understand that I must contact HR and/or my supervisor before I can return to work. Failure to do so may result in corrective action. I also understand that I may be required to provide a fitness for duty certification before being restored to employment.

Employee
Signature _____ Date _____

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 _____

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 EFML. This paragraph is optional.