

FAMILY FIRST CORONAVIRUS RESPONSE ACT (FFCRA) EMERGENCY PAID SICK LEAVE AND EMERGENCY FMLA REQUEST FORM

EMPLOYEE INFORMATION	
Employee Name:	SSN (Last 4 Digits):
Occupation:	Department/Bureau/Division:
Employment Status: <input type="checkbox"/> PF (Permanent Full-Time) <input type="checkbox"/> PP (Permanent Part-Time) <input type="checkbox"/> SP (Seasonal Part-Time) <input type="checkbox"/> Other	
SUPERVISOR INFORMATION	
Supervisor Name:	Supervisor email/Ext:

MONTH	DATES REQUESTED	NUMBER OF HOURS/DAYS REQUESTED
TOTAL NUMBER OF HOURS/DAYS REQUESTED:		

I CERTIFY THAT I AM UNABLE TO WORK (OR TELEWORK) FOR THE FOLLOWING REASON:

- 1) I am subject to a **federal, state, or local quarantine or isolation** order related to COVID-19 that specifically prevents me from working.
Name of the government entity issuing the order:
- 2) I have been **advised by a health care provider to self-quarantine** because of concerns related to COVID-19.
Name of the advising healthcare provider:
- 3) I have **symptoms of COVID-19** and I am seeking (or have sought) a diagnosis.
- 4) I am **caring for another individual** who is subject to quarantine or has been advised by a health care provider to self-quarantine related to COVID-19.
Name of person(s) I am caring for and our relationship:

Name of the government entity issuing the order:

OR
Name of the advising healthcare provider:

- 5) I **need to care for my child(ren)** because their school or childcare provider is closed or unavailable because of COVID-19. I certify that **no other suitable person is available to care for the child(ren) during the period of requested leave.** If listed child is over 14, I further certify that there are special circumstances that require me to provide care for them. Please check all the boxes that apply below.
Name(s) and age(s) of child(ren):

Name of closed school(s) or place(s) of care:

- | | |
|--|---|
| <input type="checkbox"/> I have been employed for at least 30 days. | <input type="checkbox"/> I elect to use unpaid leave for first 10 days. |
| <input type="checkbox"/> I am unable to work or telework. | <input type="checkbox"/> I elect to use accrued leave for first 10 days. |
| <input type="checkbox"/> I am not an Emergency or Health Care Responder. | <input type="checkbox"/> I elect to use emergency sick leave for first 10 days. |



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6) I am experiencing **other conditions substantially similar** to COVID-19 as specified by the Department of Health and Human Services.

I certify that I am unable to work or telework, and that the information in this document is truthful and I also understand that misrepresenting my need for leave is grounds for discipline, up to and including termination.

Employee Signature

Date

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COMPLETED BY EMPLOYEE'S DEPARTMENT

If employment status checked is "Other," please indicate the employment status here: _____

- Employee is eligible for up to 80 hours of paid sick leave (prorated for part-time employees).
- Employee is eligible for up to 12 weeks of expanded FMLA leave, under reason 5 above. The first 10 days may be unpaid or employee may use accrued paid leave or emergency sick leave. Remaining leave time is at two-thirds of the regular rate of pay.

If due to a work-related exposure:

Did the employee complete the DWC-1 Form? YES - If yes, please attach form. NO

iVOS Entry and Claims Examiner Notification completed? YES NO

Administrative Officer Name

Signature

Date

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COMPLETED BY HUMAN RESOURCES

APPROVED DENIED

COMMENTS

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HR Director or Designee Name

Signature

Date

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