Request for Leave under the Families First Coronavirus Response Act (FFCRA)
Effective April 1, 2020 – December 31, 2020

Name:			**Phone:**	
Department:			**Hire Date:**	
Estimated Start Date of Leave:		**Estimated End Date of Leave:**		

TYPE OF LEAVE REQUESTED

Emergency Paid Sick Leave Act Leave – The FFCRA provides up to 80 hours (10 workdays)/112 hours for sworn Fire shift employees) of emergency paid sick leave to full-time employees who are unable to work, either onsite or remotely, due to COVID-19, and for specific reasons listed below. Part-time employees are entitled to emergency paid sick leave based on the number of hours the employee works, on average, over a two-week period. The Department of Labor (DOL) provided additional guidance related to determining the appropriate number of hours if a part-time employee's schedule is unknown or varies. See the below requirements necessary for employees who make such requests for this emergency paid sick leave (COVID-19-Sick for all options with the exception of reason #5 COVID-19 Sick Childcare). **Note**: Employees do not get a new 80 hours for each reason.

I am unable to work due to the following reason:

Check the applicable box:

☐ 1. I am subject to a federal, state, or local quarantine or isolation order related to COVID-19, per a public health authority; specify the name of the government entity that issued this order: ____. Number of hours requested: ______

☐ 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 who provided such advice: _______________________________. Number of hours requested: _______

☐ 3. I am experiencing COVID-19 symptoms and am seeking a medical diagnosis. Number of hours requested: ________

☐ 4. I am caring for an individual subject to an order described in 1) above or 2) self-quarantined as described in 2) above; name of government entity _____________________ or name of health care provider: ______________________________. Number of hours requested: _________

☐ 5. I am caring for a child whose school or place of care is closed, or the childcare provider is unavailable for reasons related to COVID-19; name of child ______________________; name of school, childcare provider which is closed: ____________________. I certify that no other suitable person is available to care for my child. Number of hours requested: _________.

☐ 6. I am experiencing any other substantially-similarcondition specified by the Secretary of Health and Human Services. Number of hours requested: _________

Emergency Family and Medical Leave Expansion Act (Expanded FMLA - EFMLA) – The FFCRA temporarily updates the Family and Medical Leave Act (FMLA) to provide employees with up to 12 weeks of job-protected leave if they are unable to work, either onsite or remotely, as a result of their minor son's or daughter's school or child care services being closed due to the public health emergency associated with COVID-19. Employees are eligible if they have been employed for at least 30 days. The following information must be provided:

- Name of child/children being cared for: ____
- Number of expanded FMLA leave hours needed: ___________________________________
- Name of school or child care provider/center closed or unavailable related to COVID19:____
- I certify that no other suitable person is available to care for my child/children.
  - Yes
  - No

Once approved, the first two weeks (2) are unpaid; however, for those first 2 weeks, the employee may use *emergency paid sick leave* – or other available leave balances (accrued vacation; accrued sick, compensatory time) to cover this first 2-week period. After the initial two (2) week period, the employee is eligible to receive two-thirds (2/3) of their full pay for the remaining ten (10) weeks, as needed, if the employee has not opted to utilize other forms of paid leave to receive their regular rate of pay.

This EFMLA provision does not apply to any other reason for leave under the FMLA.

Check **All** Applicable Boxes:

☐ I am requesting *EFMLA leave* due to 1) my inability to work, either onsite or remotely, and 2) my minor child(ren) whose school or place of care is closed, or child care provider is not available due to COVID-19 related reasons. My request is for ☐Intermittent Leave **OR** ☐Concurrent Leave

☐ I am requesting that my *emergency paid sick leave (COVID-19-Sick Childcare)* be utilized for the first 2 weeks of *EFMLA leave (COVID-19 FMLA).*

☐ I am requesting that my available sick leave, vacation leave, and/or compensatory time be utilized for the first 2 weeks of EFMLA.

☐ If I am out longer than 2 weeks on *EFMLA leave*, I choose to use available sick leave, vacation leave, or compensatory time be applied so that I can be paid at my regular rate of pay. Otherwise, I understand that I will receive two-thirds (2/3) of my regular rate of pay.

I, (please print full name)__________________________________, certify that I am unable to work, either onsite or remotely, due to the reason(s) checked above, and have provided the above-referenced required information (see 1st page re: required information).

*Signed*____ *Date* ______________________________

Signature of Supervisor Who Received Oral Notification & Necessary Required Information:

____ *Date Received:* _________________________

HR Generalist/HR Liaison Signature: ________________________ *Date:* _________________________________

For all Expanded FMLA leave Requests, proceed to page 3 and a copy of this completed document must be scanned to the FMLA Coordinator in Human Resources, or in Fire or Police by the HR Generalist/Liaison and copying the Timekeeper(s). For Emergency Paid Sick Leave requests only (regular COVID-19 Sick only), the Timekeeper(s) must receive a copy.

For Timekeeper Use Only

Expanded FMLA Calculation (if the 2/3 amount applies) /Approval:

Period End Date	Total COVID-19 EFMLA hours requested	Other Paid Leave Hours Requested to be Applied (COVID-Sick, Sick, Vacation, Compensatory Time)*
TOTAL		

*Specify how many hours of each type of paid leave, identifying the paid leave category

Paid Sick Leave Calculation (Timekeeper):____Date:_______________

For Human Resources Use Only

HR Generalist/Liaison Completion:

Hire Date:__________________________ Status/hours work per week: ____________________________

Documentation provided (Y/N):_________ Hourly Rate of Pay: ____________________________________

Current Available FMLA Leave Balance: ____________

HR Generalist/Liaison Signature: ____ Date: _______________

FMLA Coordinator Completion:

Approved ☐ Disapproved ☐ FMLA Coordinator Signature: ______________________________ Date: ______________