Families First Coronavirus Response Act
Leave Request Form

Employee Name:	Phone Number:
Address:	Email Address:

LEAVE REQUESTED

<table>
<tr><th colspan="2">Emergency Paid Leave</th><th colspan="2">Emergency FMLA Expansion Leave</th></tr>
<tr><td>Time Permitted:</td><td>80 hours maximum for full-time employees</td><td>Time Permitted:</td><td>Up to twelve weeks total for all federal FMLA purposes</td></tr>
<tr><td>Type of Leave:</td><td>Paid Leave (total amount of pay subject to statutory limits based on qualifying reason)</td><td>Type of Leave:</td><td>First 10 work days unpaid. Next ten weeks paid (total amount of pay subject to statutory limits).</td></tr>
<tr><td colspan="2">I am unable to work (or telework) for the following reason:
Paid out at full pay (subject to caps):
☐ I am subject to a federal, state, or local quarantine or isolation order related to COVID-19.
☐ I have been advised by a health care provider to self-isolate due a diagnosis of or other concerns related to COVID-19.
☐ I am experiencing symptoms of COVID-19 and am seeking a medical diagnosis.

Paid out at 66% pay (subject to caps):
☐ I am caring for an individual who is subject to a quarantine or isolation by a federal, state, or local order or was advised by a health care provider to self-isolate.
☐ I am caring for my son or daughter because his/her school or place of care has been closed or his/her child care provider is unavailable due to COVID precautions.
☐ I am experiencing a substantially similar condition as specified by the Secretary of Health and Human Services.</td><td colspan="2">I have been employed by this employer for at least 30 calendar days, and I am unable to work (or telework) because:

☐ I am caring for my son or daughter because his/her school or place of care has been closed or his/her child care provider is unavailable due to COVID precautions.</td></tr>
<tr><td colspan="2">Date Leave Will Begin:</td><td colspan="2">Date Leave Will Begin:</td></tr>
<tr><td colspan="2">Anticipated Date You Will Return:</td><td colspan="2">Anticipated Date You Will Return:</td></tr>
<tr><td>☐ Continuous</td><td>☐ Intermittent*</td><td>☐ Continuous</td><td>☐ Intermittent*</td></tr>
<tr><td colspan="2">Explain proposed schedule for intermittent leave:_____
_____
*Intermittent leave is only permitted for child care leave. Proposed schedule for intermittent leave is subject to approval of the Employer.</td><td colspan="2">Explain proposed schedule for intermittent leave:_____
_____
_____
*Proposed schedule for intermittent leave is subject to approval of the Employer.</td></tr>
</table>

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Please indicate the following:	Please indicate the following:
☐ I wish to continue my health insurance benefits while on leave. I understand that I am responsible for making timely payments for my portion of the premiums. Further information on the process for remitting my portion of the premiums will be provided. ☐ I wish to substitute accrued paid leave to supplement my time off that would otherwise be paid out at 66% as follows: ____Leave Hours (Employee may not earn more than 100% of their daily earnings.)	☐ I wish to continue my health insurance benefits while on leave. I understand that I am responsible for making timely payments for my portion of the premiums. Further information on the process for remitting my portion of the premiums will be provided. ☐ I wish to substitute paid leave for the initial 10 unpaid working days of FMLA as follows: ____FFCRA Emergency Paid Leave ____Leave Hours ☐ I wish to substitute accrued paid leave to supplement my time off that would otherwise be paid out at 66% as follows: ____Leave Hours (Employee may not earn more than 100% of their daily earnings.)

Documentation Requirements

If you are requesting leave based on a quarantine or self-isolation please provide:

1. The name of the governmental entity ordering quarantine or the name of the health care professional advising self-isolation; and
2. If you are taking leave to care for someone subject to a quarantine order or self-isolation advice, the name of the person you are caring for and their relationship to you.

Name of Entity Ordering Quarantine or Name of Health Care Professional Advising Self-Isolation:	
Name of Person Employee is Caring for:	
Relationship to Employee:	

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Documentation Requirements, continued

If you are requesting FFCRA leave because you are unable to work or telework due to the need to care for a son or daughter due to a school closing or childcare provider unavailability, please provide the following:

1. The name and age of your child (or children) to be cared for;
2. The name of the school that has closed or place of care that is unavailable; **(Please attach supporting documentation of unavailability, such as an email from the school or place of care)**
3. A representation that no other person will be providing care for the child during the period for which you are receiving leave; and
4. With respect to your inability to work or telework because of a need to provide care for a child older than fourteen during daylight hours, a statement that special circumstances exist requiring you to provide care.

	Name of Child	***Age of Child***	***Name of School or Place of Care***
1.			
2.			
3.			
4.			
5.			

☐ By checking this box and signing below, you represent that no other person will be providing care for the above-listed child(ren) during the period for which you are receiving leave.

☐ By checking this box and signing below, you represent that special circumstances exist requiring you to provide care, during daylight hours, for any child listed above that is older than fourteen.

The employer reserves the right to tentatively approve your request for leave pending receipt of documentation. The employer reserves the right to request additional documentation or clarification of the documentation provided.

By signing below, you certify that the above information is accurate and complete.

_____ _____

Employee Signature Date