

**Family First Coronavirus Response Act (FFCRA)**  
**Request for Leave Form**

Effective April 1, 2020 –December 31, 2020 (2021 EXTENSION)

**I. Type of Leave Requested**

Please check the appropriate box or boxes:

- I am seeking leave under the Emergency Family and Medical Leave Expansion Act to care for my son or daughter under 18 years of age or a covered adult son or daughter (i.e., one who is 18 years of age or older, who (1) has a mental or physical disability and (2) is incapable of self-care because of that disability), whose school or place of care has been closed, or whose child care provider is unavailable, due to a COVID-19 related public health emergency.

If you checked this box, please provide the following information:

- Dates for which you are requesting leave (maximum of 12 workweeks):  
From: \_\_\_\_\_ To: \_\_\_\_\_
- Name(s) and age(s) of the child (or children) to be cared for: \_\_\_\_\_  
\_\_\_\_\_
- Name of the school or place of care that closed or the child care provider that is unavailable: \_\_\_\_\_  
\_\_\_\_\_
- Will any other person be providing care for the child during the period for which you are seeking leave: Yes / No (please circle one)
- Are you unable to work, including by means of telework, due to your need to care for your son or daughter: Yes / No (please circle one)  
If yes, please explain: \_\_\_\_\_  
\_\_\_\_\_

If you are only seeking Emergency Family and Medical Leave, please skip Section II and complete Section III below.

- I am seeking leave under the Emergency Paid Sick Leave Act.

If you checked this box, please answer the questions in Section II beginning on the following page.

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### **II. Explanation for Need for Emergency Paid Sick Leave**

A. I am seeking Emergency Paid Sick Leave for the following reasons (check all appropriate boxes and provide the requested information for all boxes checked):

- 1. I am subject to a Federal, State or local quarantine or isolation order
  - Identify the government entity that issued the quarantine or isolation order:  
\_\_\_\_\_
  
- 2. I have been advised by a health care provider to self-quarantine due to concerns related to COVID-19
  - Identify the health care provider: \_\_\_\_\_
  
- 3. I am experiencing symptoms of COVID-19 and seeking a diagnosis
  - Please note that leave taken for this reason is limited to the time you are unable to work because you are taking affirmative steps to obtain a medical diagnosis (e.g., for time spent making, waiting for, or attending an appointment for a test for COVID-19). You must contact Human Resources immediately upon receiving your diagnosis.
  
- 4. I am caring for an individual who is subject to a Federal, State or local quarantine or isolation order or am caring for an individual who has been advised by a health care provider to self-quarantine due to concerns related to COVID-19
  - Identify the name of the person for whom you are caring and your relationship to that person: \_\_\_\_\_
  - Identify the name of the government entity that issued the quarantine or isolation order or the health care provider that advised the individual to self-quarantine:  
\_\_\_\_\_
  
- 5. I am caring for a son or daughter because my son or daughter's school or place of care has been closed or the child care provider of my son or daughter is unavailable, due to COVID-19 precautions
  - Name and age of the child (or children) to be cared for: \_\_\_\_\_

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- Name of the school or place of care that closed or the child care provider that is unavailable: \_\_\_\_\_  
\_\_\_\_\_
  
- Will any other person be providing care for the child during the period for which you are seeking leave: Yes / No (please circle one)

6. I am experiencing a substantially similar condition specified by the Department of Health and Human Services in consultation with the Department of Labor

B. I am seeking Emergency Paid Sick Leave for the following dates (maximum of 80 hours):

From: \_\_\_\_\_ To: \_\_\_\_\_

C. Are you unable to work, including by means of telework, due to the reasons/boxes checked in Part A above: Yes / No (please circle one)

If yes, please explain: \_\_\_\_\_  
\_\_\_\_\_

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**III. Employee Identification and Signature**

Name (Print): \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Work Location: \_\_\_\_\_

Employees should submit completed forms with the necessary documentation to **Human Resources**. Also, please contact **YOUR SUPERVISOR** if you wish to supplement any unpaid portion of your requested emergency family medical leave or emergency paid sick leave with your available paid leave. An additional regular **REQUEST FOR LEAVE FORM WILL BE REQUIRED FROM THE EMPLOYEE** to supplement any portion of unpaid leave using the Employee's accrued leave balances for time away from work.