

Leave Under the Families First Coronavirus Response Act (FFCRA) Request and Certification Form

To request Emergency Paid Sick Leave (EPSL) or paid FMLA Public Health Emergency Leave as provided under the FFCRA, please complete the following Request and Certification Form and submit to the General Manager as soon as possible, but not later than five (5) working days after the first workday missed. For FMLA Public Health Emergency Leave, only leave required for reason No. 5 below applies.

LEAVE REQUEST INFORMATION

Employee Name (Print):

Department:

Manager Name:

Requested Start Date:

Estimated End Date:

EMPLOYEE CERTIFICATION IN SUPPORT OF LEAVE REQUEST

The reason for this leave request is (check the appropriate reason below):

- 1 ☐ 1. I am subject to a federal, state, or local quarantine or isolation order related to COVID-19.

Name of governmental entity ordering quarantine/isolation:

- 2 ☐ 2. My health care provider advised me to self-quarantine due to concerns related to COVID-19.

Identify the health care provider's name, specialty, and address:

- 3 ☐ 3. I am experiencing symptoms of COVID-19 and seeking a medical diagnosis.

Identify the health care provider's name, specialty, and address:

- 4 ☐ 4. I am caring for an individual who is subject to either Reason 1 (quarantine/isolation order) or 2 (self-quarantine) above.

Identify the name of the individual and relationship to you:

Is the individual unable to care for him/herself and dependent on you for care? ☐ Yes ☐ No.

Does the individual reside in your home? ☐ Yes ☐ No.

For Reason 1, name of governmental entity ordering quarantine/isolation:

For Reason 2, identify the health care provider's name, specialty, and address:

- 5 ☐ 5. I am caring for my son or daughter whose primary or secondary school, or place of care, has been closed, or my child care provider is unavailable due to COVID-19 precautions. My son or daughter is under age 18 (or over 18 and incapable of self-care due to a disability).

Name and ages of all children needing care:

Name of school, place of care, or child care provider that is closed/unavailable due to COVID-19:

By checking here, I am representing that no other person is available to provide care to the child(ren) listed above during the period for which leave is requested, including a co-parent or co-guardian: ☐

For any child ages 15, 16, or 17 who needs care during daylight hours, I hereby represent that there are special circumstances requiring me to provide care, as follows: _____

I hereby certify that I am unable to work (or telework, if offered) due to the qualifying reason identified above: ☐ Yes ☐ No.

For Reasons 4 and 5 above, would you be able to work or telework if your schedule was changed? ☐ Yes ☐ No.

If Yes, identify the needed schedule change: _____

Have you used any EPSL time while working for any other employer since April 1, 2020? ☐ Yes ☐ No.

If Yes, identify the total number of hours you used and the identity of the employer: _____

By signing this form, I certify that the above information is truthful and accurate. I understand that my employer will rely upon this information in filing for a payroll tax credit with the Internal Revenue Service:

Employee Signature: _____ Date: _____

Head of School Signature: _____ Date: _____