An employee requesting leave under the Families First Coronavirus Response Act (“FFCRA”) may only take leave for a qualifying reason, all of which are listed below. To approve your leave request, you must provide us with information about the reason(s) for which you seek leave, and, where applicable, how you wish to be compensated.

**Please note that leave under the FFCRA will not be approved until this form and any additional documentation needed have been provided.**

1. **General Information**
2. **Name:** Click or tap here to enter text.
3. **Job Title:** Click or tap here to enter text.
4. **Date or Date(s) for which Leave is Requested:** Click or tap to enter a date. **-** Click or tap to enter a date.
5. **Are you requesting to take leave intermittently?**\* Yes  No

If yes, please specify your proposed intermittent schedule: Click or tap here to enter text.

\**Please note that intermittent leave is only available for certain types of leave, at our discretion. Requests for intermittent leave will be considered on a case-by-case basis, depending on the type of leave requested, position and business needs.*

1. **Have you taken FFCRA leave before with another employer**? Yes  No

If so, please state how much leave you took and identify the qualifying reason for which it was taken:

Click or tap here to enter text.

1. **FFCRA Qualifying Reason for Leave**

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.**

Name of governmental entity that issued the quarantine or isolation order: Click or tap here to enter text.

**2. I have been advised by a health care provider to self-quarantine due to concerns related to COVID-19.**

Name and title of health care provider**:** Click or tap here to enter text.

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

**4. I am/will be taking care of someone who (a) is subject to a Federal, State, or local quarantine or isolation order; or (b) has been advised by a health care provider to self-quarantine due to concerns related to COVID-19:**

* Name of individual for whom I am providing care: Click or tap here to enter text.
* Relationship of individual to me: Click or tap here to enter text.
* If applicable, name of governmental entity that issued the quarantine or isolation order: Click or tap here to enter text.
* If applicable, name of health care provider who recommended that the individual to whom I am/will be providing care self-quarantine due to concerns related to COVID-19: Click or tap here to enter text.

**5. I am/will be caring for my child/children whose school or place of care is closed, or whose child care provider is unavailable, due to COVID-19 precautions.** ***Employees who need leave for this reason must complete Attachment A.***

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

Describe applicable condition: Click or tap here to enter text.

1. **Compensation**

The FFCRA contains two paid leave provisions, the Emergency Paid Sick Leave Act (“EPSLA”), which provides for up to 80 hours of paid leave, and, the Emergency Family and Medical Leave Expansion (EFMLEA), which provides for up to 12 weeks of leave, the first 2 weeks of which are unpaid and the remaining 10 weeks are paid.

The EPSLA allows leave for qualifying reasons 1 through 3, which is paid at the greater of (1) your regular rate or (2) the applicable minimum wage, up to a maximum of $511 per day or $5,110 in the aggregate per employee.

The EPSLA permits leave for qualifying reasons 4 through 6, which is paid at 2/3 the greater of (1) your regular rate or (2) the applicable minimum wage, up to a maximum of $200 per day or $2,000 in the aggregate per employee.

In addition, the EFMLEA provides for leave for qualifying reason 5, which is unpaid for the first 2 weeks, but paid at 2/3 the greater of (1) your regular rate or (2) the applicable minimum wage, up to a maximum of $200 per day or $10,000 in the aggregate per employee.

**For employees taking EFMLEA leave:**

If you would like, you may but are not required to use EPSLA leave in order to receive payment during the first two weeks of EFMLEA leave. Please indicate your preference by checking the appropriate box:

I want to use any EPSLA and EFMLEA time concurrently so that any EPSLA payments for which I may be eligible will be used during the first 10 days of my leave.

I wish to take EFMLEA leave only and understand that the first 2 weeks of my leave will be unpaid unless I elect to or am required to substitute any accrued, unused time off I have available.\*

\* *Employees who are taking EFMLEA leave, but who choose not to use EPSLA leave during the first two weeks, may be required, at our discretion, to use any other accrued paid time off they have available under our existing polices, if the policies would allow use of such accrued paid time for reason 5.*

Supplementation of FFCRA benefits:

In some instances, employees may be permitted, at our discretion, to use any unused, accrued paid time off that they have available under our existing policies to supplement the pay available for leave taken under the FFCRA such that the employee receives their full normal pay during the periods of leave. If you are requesting such supplementation, please check here:

I request that I be permitted to use my accrued, unused paid time off to supplement my EFMLEA and/or EPSLA benefits so that I can receive 100% of my regular pay.

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**I certify that all information in this request for FFCRA leave, including any information in Attachment A, is true and complete.**

**I agree and acknowledge that falsified information, misrepresentations or omissions in this request or any other related materials may result in disciplinary action, up to and including termination of employment.**

**I further acknowledge and understand that, to the extent permitted by applicable law, any child care related leave will be counted as FMLA leave towards the FMLA’s 12 week leave limit (or 26 week limit for leave to care for certain service-member family members with a serious injury or illness) in a 12-month period.**

Click or tap here to enter text.Click or tap to enter a date.

Employee Signature Date

**ATTACHMENT A**

**Additional Requirements for Employees Who Need Leave to Care for their Child/Children**

1. **Names/Ages of Your Child/Children for whom You Will Be Caring**

|  | **Name of Child** | **Age** | **Names of School, Place of Care,**  **or Child Care Provider** |
| --- | --- | --- | --- |
| 1. |  |  |  |
| 2. |  |  |  |
| 3. |  |  |  |
| 4. |  |  |  |
| 5. |  |  |  |

1. **Certifications**
2. **Sole Provider Certification**

I certify and represent that no other suitable person will be providing care for the child/children described in Part A above during the period for which I am requesting child care related leave.

Click or tap here to enter text. Click or tap to enter a date.

Employee’s Signature Date

1. **Special Circumstances Requiring Leave to Care for a Child Older than Fourteen**

With respect to any child over 14 years old listed in Part A above, special circumstances exist requiring me to provide care to such child/children. Specifically, Click or tap here to enter text.

Click or tap here to enter text. Click or tap to enter a date.

Employee’s Signature Date