Families First Coronavirus Response Act, (FFCRA) Leave Application

Employee Name: _____ Application Date: _____

EIN: _____ Date of Hire: _____ 30 Days of Employment: ☐ YES ☐ NO

Telework Option Available: ☐ YES ☐ NO Verified By: _____,_____
Dept. Head, Name *Title*

Families First Coronavirus Response Act Leave Type

☐ Paid Sick Days (Self)	=	10 Days @ 100% Pay
☐ Paid Sick Days (Other Than Self)	=	10 Days @ 2/3 Pay
☐ Paid Expanded Family and Medical Leave,(FML)	=	FML 2 Weeks Unpaid 10 Weeks 2/3 Pay

Please check the appropriate box below and provide additional requested information

Paid Emergency Sick Leave

☐	Is subject to a Federal, State, or local quarantine or isolation order related to COVID-19. **Name of Government Entity Ordering Quarantine:** _____
☐	Has been advised by a health care provider to self-quarantine related to COVID-19. **Name of Health Care Provider Advising Self Quarantine:** _____
☐	Is experiencing COVID-19 symptoms and is seeking a medical diagnosis. **Name of Health Care Provider:** _____
☐	Is caring for an individual subject to an order described in (1) or self-quarantine as described in (2) **Name and Relation of Individual:** _____-_____ **Name of Government Entity Ordering Quarantine:** _____ **OR** **Name of Health Care Provider Advising Self Quarantine:** _____
☐	Is caring for his or her child whose school or place of care is closed (or childcare provider is unavailable) due to COVID-19 related reasons. **Child's Name:**_____ **Age:**_____ **Name of School/Daycare:**_____ **I attest that there is no other suitable person available to care for my child during the requested period of leave requested. ☐ YES ☐ NO** **I attest that Special Circumstances exist requiring me to provide childcare to my child, over the age of 14, during daylight hours. ☐ YES**
☐	Is experiencing any other substantially similar condition specified by the U.S. Department of Health and Human Services.
Dates of Requested Emergency Sick Leave: FROM: _____ TO: _____	

Paid Expanded Family and Medical Leave

☐	Is caring for his or her child whose school or place of care is closed (or childcare provider is unavailable) due to COVID-19 related reasons. **Child's Name:_____ Age:_____ Name of School/Daycare:_____** **I attest that there is no other suitable person available to care for my child during the requested period of leave requested. ☐ YES ☐ NO** **I attest that Special Circumstances exist requiring me to provide childcare to my child, over the age of 14, during daylight hours. ☐ YES**
Dates of Requested Expanded Family and Medical Leave: FROM: _____ TO: _____	

_____ _____

Employee Signature *Date*

*** * * * * * * * * * * BELOW FOR HR USE ONLY * * * * * * * * * ***

Supporting Documentation from Physician Provided ☐ YES ☐ NO

Supporting Documentation from School/Daycare Provided ☐ YES ☐ NO

Approved: ☐

Conditional Approval Pending Documents: ☐ Documents Needed: _____

Denied: ☐ Reason:

_____

_____

_____

Human Resources Signature: _____ Date: _____

Dept. Head Signature: _____ Date: _____