Federal Emergency Leave Form
(Paid Sick Leave; Expanded Family Medical Leave)

Name_____Position/School_____Hire Date_____

The **Families First Coronavirus Response Act (FFCRA or ACT)** requires certain employers to provide their employees with paid sick leave and expanded family and medical leave for specified reasons related to COVID-19. These provisions will apply from April 1, 2020 through December 31, 2020.

The employee should supply information supporting the need for leave for childcare purposes for either leave option described below as soon as practicable. Information for Emergency Paid Sick Leave other than for childcare should be supplied as soon as practicable after the first day of leave.

EMERGENCY PAID SICK LEAVE

Employee requests up to two (2) weeks paid leave under the Emergency Paid Sick Leave Act (EPSLA) based upon being unable to work (or telework) for the following reason:

☐ 1. Employee is subject to federal, state, or local quarantine or isolation order related to COVID-19.

Government entity/official that issued order:
_____

☐ 2. Employee has been advised by a health care provider to self-quarantine related to COVID-19.

Name of health care provider:
_____

☐ 3. Employee is experiencing COVID-19 symptoms and is seeking a medical diagnosis.

☐ 4. Employee is caring for an individual subject to a federal, state, or local quarantine, or who has been advised by a health care provider to self-quarantine.

Name of government entity/officer ordering quarantine or isolation:

_____

OR

Name of health care provider who advised the individual to self-quarantine for COVID-19 reasons:
_____

☐ 5. Employee 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 and no other suitable person is available to care for the child.

Name(s) of child/children:
_____
_____
_____

Name(s) of school(s), place(s) of care, or child care provider(s):
_____
_____
_____

☐ 6. Employee is experiencing any other substantially similar condition specified by the U.S. Department of Health and Human Services.

***According to qualifying reason, attach copy of order of isolation/quarantine; OR written documentation by health care provider who advised self-quarantine; OR copy of doctor's order for COVID-19 testing and/or diagnosis; OR, if applicable, childcare provider certification/letter of unavailability due to COVID-19 related reasons.**

The leave requested will begin on _____and end on _____.
Date ***Date***

(Note: EPSLA authorizes two [2] weeks of paid leave with limits per Federal Law subject to an eighty [80] hour "cap".)

I verify my inability to work for the above reason for the duration of the leave.

_____ _____.
Employee Signature ***Date***

Federal Emergency Leave Form
(Paid Sick Leave; Expanded Family Medical Leave)

EMERGENCY FAMILY MEDICAL LEAVE

FOR REQUESTS OF UP TO TWELVE (12) WEEKS OF EXPANDED FAMILY AND MEDICAL LEAVE, COMPLETE OR RECORD THE FOLLOWING INFORMATION.

EMPLOYEES MUST HAVE BEEN EMPLOYED FOR AT LEAST 30 DAYS PRIOR TO THEIR LEAVE REQUEST TO BE ELIGIBLE FOR EXPANDED FAMILY MEDICAL LEAVE.

☐ Employee 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 and no other suitable person is available to care for the child.

Name(s) of child/children:

_____

Name(s) of school(s), place(s) of care, or childcare provider(s):

_____

If applicable, childcare provider certification/letter of unavailability due to COVID-19 related reasons attached.

The leave requested will begin on _____and end on _____.
Date ***Date***

NOTE-Only an additional 10 weeks of paid EFMLA may be granted if employee previously used 80 hours or a prorated amount of EPSL for any of the six Department of Labor Qualifying Reasons. In this case, the first two [2] weeks of Expanded Medical Leave is unpaid, but the employee may substitute paid leave that the employee is qualified for based on the same purpose under Board policy. Leave after [2] weeks is paid subject to limits provided by federal law.

I verify my inability to work for the above reason for the duration of the leave.

_____ _____.
Employee Signature ***Date***

_____ _____.
Superintendent's/Designee's Signature ***Date***

☐ Approved ☐ Not Approved

If not approved, list reason and brief summary of communication(s) allowing employee to explain deficiency:_____

_____