**Emergency Paid Sick Leave Act & Emergency Family and Medical Leave Expansion Act**

**Employee Leave Request Form**

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

Job Position: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Circle “yes” or “no” to each question and provide any additional requested information. Please answer all questions; leave requests may be for more than one reason.**

|  |  |
| --- | --- |
|  **(1) Are you requesting leave because you have been quarantined?** |  **Yes / No** |

Date(s) of requested leave:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(maximum of two weeks/80 hours (pro-rated for part-time employees) and runs concurrent with (2) and (3))

If you answered “Yes” to (1) above, please provide: (i) a copy of the federal, state, or local government quarantine or isolation order related to COVID-19 which forms the basis of your leave request ; (ii) written documentation by a health care provider advising you to self-quarantine due to concerns related to COVID-19; or (iii) any other information you have, such as the name of the health care provider who advised you to self-quarantine due to concerns related to COVID-19.

Name of government or health care provider issuing order or advice: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |
| --- | --- |
| **(2) Are you requesting leave because you have a bona fide need to care for an individual subject to quarantine?** |  **Yes / No** |

Date(s) of requested leave:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(maximum of two weeks/80 hours (pro-rated for part-time employees) and runs concurrent with (1) and (3))

If you answered “Yes” to (2) above, please also provide: (i) a copy of the federal, state, or local government quarantine or isolation order related to COVID-19 which forms the basis of your leave request; (ii) written documentation by a health care provider advising the individual to self-quarantine due to concerns related to COVID-19 ; or (iii) any other information you have, such as the name of the health care provider who advised you to self-quarantine due to concerns related to COVID-19.

Name of government or health care provider issuing order or advice: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of individual subject to quarantine:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is your relationship to this individual? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does this individual live in your home? Yes / No

 Please provide a brief explanation of the reasons you need to care for this individual.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **(3) Are you requesting leave because you are experiencing COVID-19 symptoms and are seeking a medical diagnosis?**  |  **Yes / No** |

Date(s) of requested leave:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(maximum of two weeks/80 hours (pro-rated for part-time employees) and runs concurrent with (1) and (2))

When do you expect to obtain a medical diagnosis? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If you answered “Yes” to (3) above, as soon as reasonably possible, please provide written documentation that shows when you obtained the medical diagnosis, and from whom.

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| --- | --- |
| **(4) Are you requesting leave due to a bona fide need to care for your son or daughter (under 18 years of age, or 18 year of age or older and incapable of self-care due to a mental or physical disability) whose school or child care provider is closed or unavailable for reasons related to COVID-19?** |  **Yes / No** |

Date(s) of requested leave:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(maximum of twelve weeks/480 hours (pro-rated for part-time employees) and runs concurrent with (1) through (3))

If you answered “Yes” to (4) above, please provide written documentation indicating that the child’s school or place of care is closed, or the child’s care provider is unavailable. Satisfactory documentation includes a notice of closure or unavailability from your child’s school, place of care, or child care provider, including a notice that may have been posted on a government, school, or day care website, published in a newspaper or reported in the news, or emailed to you from an employee or official of the school, place of care, or child care provider.

Name and age(s) of child(ren):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of closed school/daycare:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

No other person is available to care for my child(ren): Yes / No

If child(ren) are over age 14 and leave requested is during daylight hours, please describe any special circumstances requiring your presence to care for your child(ren).

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**[To be eligible for leave under the Act, the employee must certify s/he is not able to telework due to their illness and/or care responsibilities. ]****[[1]](#footnote-1)1**

|  |  |
| --- | --- |
| **(5) If the company determines that your job can be performed (wholly or partially) by telework, are you able to work remotely during some or all of the requested leave?**  |  **Yes / No** |

If yes, please explain what portions of the requested leave you can telework, including any need for flexible scheduling.

If no, please explain why you are not able to perform telework during some or all of the requested leave.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**[Optional question for employers that have their own existing leave policy**]**[[2]](#footnote-2)2**

|  |  |
| --- | --- |
| **(6) Do you wish to use any existing vacation, personal, or medical or sick leave (as applicable) in lieu of [or as a supplement to] any of the paid leave options selected above?**  |  **Yes / No** |

Date(s) for which you wish to apply existing paid leave\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**NOTE: Failure to include the required documentation as specified above may result in denial of your leave request. The company reserves the right to require different or additional information if submissions are insufficient to support the need for leave. Submitting this request does not satisfy the notice requirement to request unpaid leave under the company’s existing Family and Medical Leave Act (FMLA) policy, and you should refer to that policy for directions on what additional rights you may have under the FMLA and what you must do to request other forms of FMLA leave. Eligibility for time off under the company’s existing vacation, personal, medical and/or sick leave policies also remains governed by those separate policies.**

**By signing below, I affirm that I am unable to work, including telework, for the reasons identified above.**

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

To be completed by employer:

Leave dates approved:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pay level for approved leave:\_\_\_\_\_\_\_\_\_ 100% \_\_\_\_\_\_\_\_\_\_\_2/3

Administrator signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **1 NOTE:** Emergency paid sick leave and expanded family and medical leave is not available to the extent the employee is able to telework. However, family and self-care responsibilities may interfere with any telework and it is important for employers to be flexible when considering an employee’s capability to telework. Intermittent leave (e.g., teleworking 2 days per week, taking leave 3 days per week; or teleworking 4 hours/day, taking leave 4 hours/day) is covered under FFCRA only if agreed upon by both employer and employee. [↑](#footnote-ref-1)
2. **2 NOTE:** Employer may not require use of existing vacation, sick or PTO time balances for employee absences that are due to reasons covered by the Act. However, the employer may permit employees to use such time under employer policies, as alternative to time off under the Act, or as a supplement on days for which the Act provides 2/3 pay (to make up the other 1/3 pay. This question 6 should be tailored according to the approach the employer decides to take with respect to use of existing balances. See DOL FFCRA: Questions and Answers 7, 10, 32, and 33. [↑](#footnote-ref-2)