Request for Leave of Absence

Families First Coronavirus Response Act

Employee Name:	Phone Number:
Address:	Email Address:
Emergency Contact:	Phone Number:

TYPE OF LEAVE REQUESTED

Emergency Paid Sick Leave Act		Emergency FMLA Expansion Act	
Time Permitted: Two weeks (10 days) maximum		Time Permitted: Twelve weeks total	
Type of Leave: Paid Leave		Type of Leave: Two weeks unpaid. Ten weeks paid.	
I am unable to work (or telework) for the following reason:		I am unable to work (or telework):	
I am subject to a federal, state or legal quarantine or isolation order related to COVID-19. I have been advised by a health care provider to self-quarantine due to concerns related to COVID. I am experiencing symptoms of COVID and am seeking diagnosis. I am caring for an individual who is subject to self-quarantine by a federal, state, or local order or was advised by a health care provider to self-quarantine.* I am caring for my son or daughter (under the age of 18) because school or place of care has been closed due to COVID precautions. I am experiencing other conditions substantially similar to COVID as specified by the Secretary of HHS.		I am caring for my son or daughter (under the age of 18) because school or place of care has been closed due to COVID precautions, <u>and</u> I have been employed by this employer for at least 30 calendar days.	
Date Leave Will Begin:		Date Leave Will Begin:	
Date You Will Return:		Date You Will Return:	
Continuous	Intermittent*	Continuous	Intermittent*
Explain proposed schedule for intermittent leave: ______________________________ **Intermittent leave is only permitted for child care leave. Employer and employee must agree to intermittent leave.*		Explain proposed schedule for intermittent leave: ______________________________ **Employer and employee must agree to intermittent leave.*	
Please indicate the following:			
I wish to continue my health insurance benefits while on leave. I understand that I am responsible for making timely payments for my portion of the premiums. I wish to substitute accrued PTO or sick time to supplement my paid time off as follows: ____ PTO Hours ____ Sick Time Hours (Employee may not earn more than 100% of their salary.)		I wish to continue my health insurance benefits while on leave. I understand that I am responsible for making timely payments for my portion of the premiums. I wish to substitute accrued PTO or sick time to supplement my paid time off as follows: ____ PTO Hours ____ Sick Time Hours (Employee may not earn more than 100% of their salary.)	

Job Protected Leave: Employers with 25 or more employees are required to hold the employee's position while an employee is taking leave under the Emergency Family and Medical Leave Expansion Act. If the position does not exist upon the employee's return due to economic circumstances or operating conditions, the employer is obligated to make a reasonable effort to find an equivalent position.

Maximum Leave of Absence Rights: An employee is entitled to a combined maximum of 12 weeks, including any additional federal FMLA the employee may have a taken during a 12 month period as defined by the employer.

Provide Documentation Supporting Eligibility: Please include documentation supporting eligibility for this leave. The employer reserves the right to tentatively approve your request for leave pending receipt of doctor's confirmation that you qualify. A letter from your doctor, the health care provider's name, or evidence that the daycare is closed will help expedite approval of your request. The employer is responsible for substantiation and tax credit submissions.

I certify that the above information is accurate and complete. I understand if I fail to report to work on or before the scheduled return date or fail to contact Human Resources at # ____________________, my employer may take corrective action.

______________________________ ______________________________

Employee Signature: Date   Employer Signature ☐ Approved ☐ Denied Date