

REQUEST FOR EMERGENCY SICK LEAVE AND EXPANDED FMLA

[THE FAMILIES FIRST CORONAVIRUS RESPONSE ACT]

Section 1: PERSONAL INFORMATION (Employee completes Sections 1 and 2. Submit completed form to (Personnel Department))		
Last Name:	First Name:	Employee ID:
Home Address:	Phone (Primary):	Manager:
City, State:	Email:	Job Title:
Employee Signature:	Date Submitted:	Original Hire Date:
Section 2: EMPLOYEE REQUEST (Complete the required information, check leave type, and provide attachments as required)		
I request that my leave related to Families First Act begin on _____ and end on _____. (If necessary, give approximate dates.)		
<p>The first 10 days under EXPANDED FMLA are unpaid; however, an employee may utilize paid leave under the Emergency Sick Leave Act (at 2/3 of pay) during this 10 day period. EXPANDED FMLA is paid at 2/3 of the employee's regular rate of pay. This time is not charged against the employee's accrued leave balances. The employee may request to have the remaining 1/3 of the employee's regular rate of pay paid by accrued leave.</p> <p>Pay 1/3 of pay with leave. <input type="checkbox"/> Yes <input type="checkbox"/> No and use Annual leave <input type="checkbox"/> Sick Leave <input type="checkbox"/>.</p>		
For employee's own illness, employees may use accrued vacation and sick leave once Emergency Sick Leave of 80 hours is exhausted.		
<input type="checkbox"/> Employee Illness To Self-isolate (quarantine) due to advisement from a health care provider due to COVID-19. [Emergency Sick leave may be used.] 100% of pay up to \$511.00/day	Needed: Documentation of Health Care Provider Notes/Details: <i>A Return to Work Release from a medical provider will be needed in order for employee to return to work</i>	
<input type="checkbox"/> Employee Illness A diagnosis, waiting on test results, or self-care if experiencing symptoms of COVID-19. [Emergency Sick leave may be used.] 100% of pay up to \$511.00/day	Notes/Details: <i>A Return to Work Release from a medical provider will be needed in order for employee to return to work</i>	
<input type="checkbox"/> Family Member Illness To care for a family member diagnosed with or experiencing symptoms of COVID-19. [Emergency Sick Leave may be used.] 2/3 of pay up to \$200.00/day	Needed: Documentation of Health Care Provider Notes/Details: <i>A Return to Work Release from a medical provider will be needed in order for employee to return to work</i>	
<input type="checkbox"/> Child Care due to school/daycare closing To care for your child whose school or childcare has closed or is unavailable due to COVID-19. [Emergency Sick Leave <u>and/or</u> Expanded FMLA may be used.] 2/3 of pay up to \$200.00/day	I am the only person providing care for the child during the time requested. <input type="checkbox"/> YES <input type="checkbox"/> NO I will take the leave on an intermittent basis. <input type="checkbox"/> YES <input type="checkbox"/> NO Notes/Details including name and age of child and name of closed childcare provider:	
Section 3: SUPERVISOR/MANAGER (route to Payroll Department and attach to the form 10 after Personnel Dept. Review): Complete this section last		
Name (Print):	Email:	
Signature:	Phone:	Date:
Reviewed by Personnel Department Name (Print):	Email:	
(1) Has employee had absences counted towards FMLA entitlement in the past 12 months? <input type="checkbox"/> YES <input type="checkbox"/> NO Dates: From _____ to _____ Total hours of FMLA utilized to date: _____		
(2) Does the employee plan to take the leave be taken on an intermittent basis? <input type="checkbox"/> YES <input type="checkbox"/> NO If so, please include the schedule		
(3) Leave dates authorized by the Emergency Paid Sick Leave <input type="checkbox"/> Expanded FMLA <input type="checkbox"/> NOT Eligible <input type="checkbox"/>		
(4) Leave dates authorized by the Personnel Department From _____ To _____ Signature: _____		