Request for Paid Leave under HR6201- **Families First Coronavirus Response Act (FFCRA or Act)**

The **Families First Coronavirus Response Act (FFCRA or Act)** requires certain employers to provide their employees with paid sick leave or expanded family and medical leave for specified reasons related to COVID-19. The Department of Labor's (Department) Wage and Hour Division (WHD) administers and enforces the new law's paid leave requirements. These provisions will apply from April 1, 2020, through December 31, 2020.

Employee Name: ______________________________

Dates of requested leave:_________________________

Please mark your reason for your leave of absence with "x":

1. _______________has been advised by a health care provider or employer to self-quarantine under the suspicion or confirmed case of COVID-19;

Your statement should include the name and contact information of the health care provider or foreman advising the quarantine

2. _______________is experiencing COVID-19 symptoms and is seeking a medical diagnosis;

Your statement should include when you sought medical treatment in relation to COVID-19 symptoms.

3. _______________is caring for an individual subject to an order described in (1) or self-quarantine as described in (2);

Your statement should include the name of the person you are caring for and your relation to that person.

4. _______________is caring for a child whose school or place of care is closed (or child care provider is unavailable) for reasons related to COVID-19. *You certify that you are unable to perform essential functions of your job remotely and no other person will be providing care for the child during the period for which the employee is receiving family medical leave.*

Your statement should include the age of the child (or children) to be cared for, the name of the school that has closed or place of care that is unavailable, and if your child is older than fourteen, a statement that special circumstances exist requiring the employee to provide care.

5. _______________is experiencing any other substantially-similar condition specified by the Secretary of Health and Human Services, in consultation with the Secretaries of Labor and Treasury.

Your statement should include a substantially similar condition and include the name and contact information for the health provider that made this medical diagnosis.

Please provide a statement that explains your reason for your leave of absence:____

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Employee Signature: ___________________________________ Date:__________

HRM Only Section:
□ Approve □ Not Approved
Reason____
HRM initials: ______________

Date notified EE/Payroll:
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