APPENDIX 1
Families First Coronavirus Response Act (FFCRA) Leave Request Form

Employee's Name:	**Facility/Line of Business/Staff Office:**

Emergency Paid Sick Leave	**Expanded FMLA Leave**
Time Permitted: Up to 80 hours for a full-time employee; number of hours normally worked over a two-week period for a part-time employee. **Type of Leave**: Paid leave at a limited rate, depending on the reason for the leave.	**Time Permitted**: 12 weeks total (counts toward the total 12 workweeks of FMLA leave to which employees are normally entitled in a 12-month period). **Type of Leave**: Two weeks unpaid, 10 weeks paid leave at a limited rate. Employee may substitute any paid leave for any or all of this period.
I am unable to work (or telework) because:	**I am unable to work (or telework) because:**
☐ (1) I am subject to a federal, state, or local quarantine or isolation order related to COVID-19. ☐ (2) I have been advised by a health care provider to self-quarantine due to concerns related to COVID-19. ☐ (3) I am experiencing COVID-19 symptoms and am seeking a medical diagnosis. ☐ (4) I am caring for an individual subject to a federal, state, or local quarantine or isolation order related to COVID-19 or who has been advised by a health care provider to self-quarantine due to concerns related to COVID-19. ☐ (5) I am caring for my son or daughter whose school or place of care is closed or whose childcare provider is unavailable due to COVID-19 related reasons. ☐ (6) I am experiencing a substantially-similar condition specified by the U.S. Department of Health and Human Services, in consultation with the Secretary of Treasury and Secretary of Labor.	☐ I am unable to work or telework because I am caring for my son or daughter whose school or place of care is closed or whose childcare provider is unavailable due to COVID-19 related reasons.
Anticipated leave start date:	Anticipated leave start date:
Anticipated leave end date:	Anticipated leave end date:
☐ Continuous ☐ Intermittent*	☐ Continuous ☐ Intermittent*
Explain proposed schedule for intermittent leave: **Intermittent leave must be agreed upon by the manager and the employee. In accordance with the FFCRA MOU, such requests will not be unreasonably denied.*	Explain proposed schedule for intermittent leave: **Intermittent leave must be agreed upon by the manager and the employee. In accordance with the FFCRA MOU, such requests will not be unreasonably denied.*

Please note the following limitations on FFCRA Paid Leave and indicate how you wish to cover your anticipated time off below.	
For qualifying reasons (1) through (3) above, employees will receive pay at a regular rate of pay. Pay for these qualifying reasons will not exceed $511 per day, and $5110 in total. For qualifying reasons described in (4) through (6), an employee will receive pay for each hour of Emergency Paid Sick Leave taken at 2/3 of the FLSA-based regular rate of pay. Pay for these qualifying reasons will not exceed $200 per day, and $2000 in total. *Utilizing this leave may result in an overpayment, triggering a debt to the U.S. Government.*	Under FFCRA, the first two work weeks (or first 10 work days) of Expanded FMLA leave is unpaid leave. An employee may opt to do the following for the first ten days: • Substitute Emergency Paid Sick Leave for up to 80 hours at 2/3 of the FLSA-based regular rate of pay. Pay will not exceed $200 per day, and $2000 in total. If the employee has already used any portion of the Emergency Paid Sick Leave for other qualifying reasons, that leave is not available for substitution. *Utilizing this leave may result in an overpayment, triggering a debt to the U.S. Government.* or • Substitute any other paid leave. During the remaining 10 workweeks of Expanded FMLA Leave, an employee may: • Utilize the Expanded FMLA Leave entitlement and receive pay for each hour of Expanded FMLA Leave at no less than 2/3 of the FLSA-based regular rate of pay for the number of hours the employee would otherwise be scheduled to work. In this instance, pay will not exceed $200 per day, and $10,000 in the aggregate for the remaining ten weeks of FMLA leave ($12,000 total if the employee used Emergency Paid Sick Leave for the first two weeks). *Utilizing this leave may result in an overpayment, triggering a debt to the U.S. Government.* or • Substitute any paid leave. If an employee substitutes paid leave, that leave will be charged against the employee's leave balance.
I wish to cover my anticipated time off with the following hours: (*Please fill in the number of hours for each category of leave.)* _____ Emergency Paid Sick Leave Hours* _____ Accrued Annual Leave Hours _____ Expanded FMLA Leave Hours* _____ Accrued Sick Leave Hours _____ Credit Hours _____ Compensatory Time Hours ** Utilizing this leave may result in an overpayment, triggering a debt to the U.S. Government.*	
Employee's Signature:	**Date:**

Employee Documentation of Need for Emergency Paid Sick Leave and/or Expanded FMLA Leave

Qualifying Reason	**Documentation**
I am subject to a federal, state, or local quarantine or isolation order related to COVID-19.	Name of government entity that issued my quarantine or isolation order:
I have been advised by a health care provider to self-quarantine due to concerns related to COVID-19.	Name of the health care provider who advised me to self-quarantine due to concerns related to COVID-19:
I am experiencing COVID-19 symptoms and am seeking a medical diagnosis.	Name of government entity that issued my quarantine or isolation order or name of the health care provider who advised me to self-quarantine due to concerns related to COVID-19:
I am caring for an individual subject to a federal, state, or local quarantine or isolation order related to COVID-19 or who has been advised by a health care provider to self-quarantine due to concerns related to COVID-19.	Name of government entity that issued my quarantine or isolation order or name of the health care provider who advised me to self-quarantine due to concerns related to COVID-19:
I am caring for my son or daughter whose school or place of care is closed or whose childcare provider is unavailable due to COVID-19 related reasons.	Name of child: Name of school, place of care, or childcare provider: ☐ I hereby certify that there is no other suitable person who will be caring for my son or daughter during the period of Emergency Paid Sick Leave or Expanded FMLA Leave.

(for Agency use)	
☐ Your request for Emergency Paid Sick Leave and/or Expanded FMLA Leave is approved. ☐ I have determined that you are not eligible for Emergency Paid Sick Leave and/or Expanded FMLA Leave for the following reason(s): _____ _____ ☐ Your request for Expanded FMLA Leave is denied in whole or in part because you have already taken some or all of the 12 workweeks of FMLA available in a 12-month period. Explain: _____ _____ ☐ Your request for intermittent Expanded FMLA Leave requires more discussion or is denied for the following reasons: _____ _____	
Manager's Signature:	**Date:**