

City of  
Holyoke, Massachusetts  
Personnel Department  
20 Korean Veterans Plaza Holyoke, MA 01040

**Employees Request for Expanded Sick Leave and/or  
Family or Medical Leave related to COVID-19**

The Families First Coronavirus Response Act (FFCRA) provides certain employees with expanded Family Medical Leave access and emergency paid sick leave. More information on these benefits can be found here:

[https://www.dol.gov/sites/dolgov/files/WHD/posters/FFCRA\\_Poster\\_WH1422\\_Non-Federal.pdf](https://www.dol.gov/sites/dolgov/files/WHD/posters/FFCRA_Poster_WH1422_Non-Federal.pdf)

This Eligibility Determination Request Form will be submitted confidentially to the Human Resources Department to request FMLA job protections as available for COVID-19 purposes, as well as emergency paid sick leave. Please submit this request as soon as possible. A late submission of this form may delay the job protections provided by FMLA.

Department / Work Location: \_\_\_\_\_ Direct Supervisor: \_\_\_\_\_

Employee's Full Legal Name: \_\_\_\_\_

Email: \_\_\_\_\_ Best Phone Number to Reach You: \_\_\_\_\_

In an effort to serve you in the best possible way due to COVID-19, all responses will go to the email you provide on this form.

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**Use this section to apply for Federal Sick Leave under the FFCRA.  
You may request up to 2 weeks for medical purposes including quarantine and/or isolation.**

Requested Leave Start Date: \_\_\_\_\_ Date Leave is Expected to End: \_\_\_\_\_

I hereby request leave for the following reason(s):

- 1. I am subject to a federal, state, or local quarantine or isolation order related to COVID-19; **Name of the issuing government agency for the quarantine or isolation order and effective dates- documentation attached**
- 2. I have been advised by a health care provider, and/or local Board of Health or public health department, to self-quarantine due to concerns related to COVID-19; **Name of health care provider advising me to self-quarantine and effective dates- documentation attached**
- 3. I am experiencing symptoms for COVID-19 and seeking a medical diagnosis; **Name of health care provider from which I am seeking medical diagnosis and applicable appointment and testing dates- documentation attached**
- 4. I am caring for an individual who is subject to one of the orders as described in #1 or #2 above; **Name of health care provider advising the individual I am caring for to self-quarantine and effective dates- documentation attached**
- 6. I am experiencing another substantially similar condition, (such condition must be approved by the US Department of Health & Human Services to qualify). **documentation attached**

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\*Individual(s) for whom you are providing care: \_\_\_\_\_

**Must provide full name, date of birth, and relationship.**

**Documentation must be provided to support your need for leave:** Documentation includes quarantine or isolation orders, diagnosis, or doctor's recommendations. Multiple files may be attached. Leave will only be granted upon receipt of sufficient supporting information.

**Signature required on reverse side of this form**

**Use this section to apply for Public Health Emergency Leave under the FFCRA.  
You may request up to 12 weeks' childcare reasons.**

Requested Leave Start Date: \_\_\_\_\_ Date Leave is Expected to End: \_\_\_\_\_

I hereby request leave for the following reason(s):

5. I am caring for my son or daughter, younger than 18 years of age, whose primary or secondary school or place of care has been closed, or my childcare provider is unavailable, due to COVID-19 precautions; and,

I attest that no other suitable person will be providing care for my child(ren) during the period for which I am receiving family medical leave.

Due to: \_\_\_\_\_

I attest to special circumstances requiring my need for leave to care for my son or daughter ages 15-17

Special circumstances are: \_\_\_\_\_

\*Individual(s) for whom you are providing care: - **Must provide full name, date of birth, and relationship**

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

4. \_\_\_\_\_

5. \_\_\_\_\_

6. \_\_\_\_\_

Name and address of School(s) or Childcare Provider(s):

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**Documentation must be provided to support your need for leave:**

If you are requesting leave to care for a child whose school or place of care is closed, you are required to provide that documentation only if closed beyond the Governor's stated date of closing (currently 5/4/2020).

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**Signature required here for all FFCRA Leave Requests.**

I hereby certify that the information given above is true and correct to the best of my knowledge. I understand that misrepresentation or omission of the reason for leave or any of the facts supporting the need for leave will result in denial of the leave and disciplinary action up to and including discharge. I certify that I am requesting this leave because I am unable to work (onsite or remotely) due the reason(s) stated above. I authorize my employer to obtain medical or other information to support my request for leave.

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Dated