Request for Leave under the Families First Coronavirus Response Act ("FFCRA")

The Families First Coronavirus Response Act (FFCRA or Act) requires certain employers to provide their employees with paid sick leave and expanded family and medical leave for specified reasons related to COVID-19.

These provisions will apply from April 1, 2020 through December 31, 2020. Please read the attached Families First Act FAQs for more information about eligibility, leave entitlement and other important information.

Employees shall request leave as soon as practicable and shall certify the need for leave in writing at the time of the request by completing the form below. The City may deny this leave to any employee who is a health care provider or emergency responder.

Request for Emergency FMLA Leave ("EFMLA") and/or Emergency Paid Sick Leave ("EPSL")

Employee Name:_____

Department:_____ Position: _____

Status: Regular Full or Part Time☐ Fixed-Term☐ Temporary☐

I have read the Families First Coronavirus Response ace ("FFCRA") FAQs and am requesting (check one or both):

☐ Family and Medical Leave Act Public Health Emergency Leave (Emergency FMLA or "EFMLA")[1]

☐ Emergency Paid Sick Leave ("EPSL")[2]

[1]If approved for EFMLA, the first 10 days of this leave are unpaid but you have the option to substitute your pay during those 10 days with any available accrued vacation personal, sick, or EPSL. If you want to substitute your pay with leave other than EPSL, complete Section One of this form and request the vacation, personal, or sick leave as you would normally.

[2]If you are requesting EFMLA and want to substitute your pay for the first 10 days with EPSL, check both options above and complete both Sections of this form.

SECTION ONE: CERTIFICATION OF NEED FOR EMERGENCY FMLA ("EFMLA")

Have you taken leave under FMLA in the past 12 months? Yes ☐ No ☐

Compensation:

First 10 days of Leave is without pay unless the following is designated:

I wish to use the following leave during the first 10 days of EFMLA:

Leave without pay ☐ Sick Leave ☐ Float ☐

Vacation ☐ Comp Time ☐ Admin ☐

Emergency Paid Sick Leave ☐ *(Complete Certification of Need for Emergency Paid Sick Leave below)*

Pay as of the 11th day of Leave

Pay under EFMLA beginning on the 11th day is based on 2/3 of your regular pay, subject to a cap of $200 per day ($10,000 in total).

I, _____, certify that I have a child who is under the age of 18, whose school or place of care has been closed, or whose child care provider is unavailable due to a COVID–19 emergency declared by either a Federal, State, or local authority. Due to the need to care for my child, I am unable to work (or telework). I understand that if my childcare needs change, I must immediately inform my supervisor and the City and I may be directed to report back to work (or telework).

Leave Start Date_____ Expected End Date:_____

Or - Intermittent leave (date range, hours per week, reason for intermittent request)

_____

Signature:_____ Date:_____

HR Use

Approved By _____ Denied (reason) _____

Hire Date _____ Notes (FMLA use, etc.) _____

_____

_____

SECTION TWO: CERTIFICATION OF NEED FOR EMERGENCY PAID SICK LEAVE ("EPSL")

I, _____, certify that I am unable to work (or telework) for one of the following reasons:

(initial one)

	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 symptoms of COVID-19 and am seeking a diagnosis.
	4	I am caring for an individual under a quarantine or isolation order, or who has been advised by a health care professional to self-quarantine. *Relationship to Individual*:
	5	I am caring for a child due to school closure or unavailability of the child's care provider due to COVID-19*. (Complete Section 1 above - Certification of Need for Emergency Family Medical Leave)*
	6	I am "experiencing any substantially similar condition specified by the Secretary of Health and Human Services in consultation with the Secretary of the Treasury and Secretary of Labor." *(this section is unavailable until further direction is received from the Health and Human Services department.)*

Daily caps: Leave taken for reasons #1-3 above is paid at your regular rate of pay, capped at $511 per day ($5,110 in total). Leave taken for reasons #4-6 above is paid at 2/3 your regular rate of pay, subject to a cap of $200 per day ($2,000 in total).

I understand that if my circumstances change so that I am no longer eligible under one of the qualifying categories, I must immediately inform my supervisor and Human Resources and I may be directed to report back to work (or telework).

Leave Start Date _____ Expected End Date _____

Or - Intermittent leave (For reason 5 above ONLY; must be taken in full-day increments)

Please note date ranges, hours per week:

_____

Signature:_____ Date:_____

HR Use: Approved by: _____

Leave Code: 61cvda for 1-3 Denied (reason) _____

Leave Code: 61cvdb for 4-6 Notes (FMLA use, etc.) _____

Hourly Rate _____ _____

Daily Max Hours _____ *(*any remaining regularly scheduled hours will be unpaid.*