# COVID-19 Leave and Accommodation Request Form

## DIRECTIONS:

An employee may be entitled to an accommodation, paid leave under the Families First Coronavirus Response Act ("FFCRA"), or unpaid leave under the Family Medical and Leave Act ("FMLA") if the employee satisfies eligibility standards. To be considered for leave and/or an accommodation, the employee must complete and submit this request form to:

**Stonington Public Schools**
**Return to: Therese Roush or Shana Howrd**
**Email: therese.roush@stoningtonschools.org**
**Shana.howard@stoningtonschools.org**
**Or by Interoffice mail**

**Before completing this form, please review the COVID-19 Leave and Accommodation Information Sheet.**

## SECTION I – EMPLOYEE

### Part A: Employee Information

Employee Name: _____

Home Address: _____

Telephone Number: _____

Email: _____

School: _____

Position: _____

### Part B: Reason for Leave or Accommodation

**FFCRA Leave**

If requesting FFCRA leave, please check below applicable box. I certify that I am unable to work because:

☐ **I am subject to a Federal, State, or local quarantine or isolation order related to COVID-19.**

Name of Government Entity that issued the Quarantine or Isolation Order:

_____

☐ **I have been advised by a health care provider to self-quarantine due to concerns related to**

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**COVID-19.**

Health Care Provider's Name: _____

☐ **I am experiencing COVID-19 symptoms and am seeking a medical diagnosis.**

☐ **I am experiencing a substantially similar condition to COVID-19 as specified by the Secretary of the U.S. Department of Health and Human Services.**

☐ **I am caring for an individual subject to a Federal, State, or local quarantine or isolation order related to COVID-19.**

Individual's Name: _____

Relation to Employee: _____

Name of Government Entity that issued the Quarantine or Isolation Order:

_____

☐ **I am caring for an individual who has been advised by a health care provider to self-quarantine due to concerns related to COVID-19.**

Individual's Name: _____

Relation to Employee: _____

Health Care Provider's Name: _____

☐ **I need to care for my son or daughter who is under age 18, or 18 years of age or older who is incapable of self-care because of a mental or physical disability, because my son's or daughter's school or place of care is closed, or child care provider is unavailable, due to COVID-19 related reasons.**

Name of Son or Daughter: _____

Name of School, Place of Care, or Child Care Provider that has closed or become unavailable:

_____

I hereby confirm that no other suitable person will be caring for the above-named Son or Daughter during the period of time for which I am requesting leave. _____

(Initial Above)

## "High Risk" Accommodation

If you or an individual you reside with are "high risk" or "might be high risk" for severe illness from COVID-19 and are requesting a reasonable accommodation, please check the below applicable box and medical documentation section.

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**"High Risk" Conditions:** The CDC has declared, based on current evidence, people with the following conditions **are at increased risk** of severe illness from COVID-19:

- Cancer
- Chronic kidney disease
- Chronic obstructive pulmonary disease (COPD)
- Immunocompromised state (weakened immune system) from solid organ transplant
- Obesity (body mass index [BMI] of 30 or higher)
- Serious heart conditions, such as heart failure, coronary artery disease, or cardiomyopathies
- Sickle cell disease
- Type 2 diabetes mellitus

☐ I have one of the above conditions, and, therefore, have an increased risk for severe illness from COVID-19, as defined by the CDC.

☐ I reside with someone who has one of the above conditions, and, therefore, has an increased risk for severe illness from COVID-19, as defined by the CDC.

**"Might be at High Risk" Conditions:** The CDC has declared, based on current evidence, people with the following conditions **might be at an increased risk** for severe illness from COVID-19.

- Asthma
- Cerebrovascular disease (affects blood vessels and blood supply to the brain)
- Cystic fibrosis
- Hypertension or high blood pressure
- Immunocompromised state (weakened immune system) from blood or bone marrow transplant, immune deficiencies, HIV, use of corticosteroids, or use of other immune weakening medicines
- Neurologic conditions, such as dementia
- Liver disease
- Pregnancy
- Pulmonary fibrosis (having damaged or scarred lung tissues)
- Smoking
- Thalassemia (a type of blood disorder)
- Type 1 diabetes mellitus

☐ I have one of the above conditions, and, therefore, I might be at an increased risk for severe illness from COVID-19, as defined by the CDC.

☐ I reside with someone who has one of the above conditions, and, therefore, might be at an increased risk for severe illness from COVID-19, as defined by the CDC.

**Medical Documentation:**

☐ **I have included medical documentation to support my request.**

**Note:** The Genetic Information Nondiscrimination Act of 2008 ("GINA") prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic information," as defined by GINA, includes an individual's family medical history, the results of an individual's or family

member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

☐ **I have not included medical documentation to support my request because the condition(s) is obvious and/or I have previously submitted medical documentation related to this condition(s), and no additional medical documentation is needed. Please Explain Further:** _____

_____

_____

_____

## FMLA Leave

You will be required to fill out the appropriate FMLA forms and provide medical certification, if applicable. The Human Resources Department will notify you to inform you whether you are eligible for FMLA leave. If you would like to be considered for FMLA leave, please check the below applicable box:

☐ I have a qualifying serious health condition that makes me unable to perform my job.

☐ I am caring for an immediate family member who has a qualifying serious health condition.

## Part C: Telework or Leave Request

All employees who are requesting telework or leave must check below applicable box:

☐ I am requesting the ability to telework.

☐ I cannot telework and am requesting leave. If requesting leave, please provide the following information:

Requested Leave Start Date: _____/_____/_____

Expected Return to Work Date: _____/_____/_____

## Part D: Employee Certification and Signature

I certify that the above information is accurate and complete. I further acknowledge that I have read the "COVID-19 Leave and Accommodation Information" document. I agree to fully cooperate with the Board in responding to my request, including supplying the Human Resources Department with documentation to support my request if needed. I understand that by submitting this form I am not guaranteed leave and/or an accommodation. I understand that if I fail to report to work on or before my scheduled return date and fail to communicate changes in my schedule with my supervisor, I may be subject to discipline in accordance with

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Board policies and/or applicable contracts.

Employee Signature: _____ Date: ____ / ____ / ____

---------- **Do Not Write Below This Line** ----------

## SECTION II – EMPLOYER

**Requested Received By:** _____ **Date:** ____ / ____ / ____

**Request Approved/Denied By:** _____ **Date:** ____ / ____ / ____

**Applicable Leave and/or Accommodation -**

**Paid Sick Leave (ESPLA)**

☐ **Approved** **Start Date:** ____ / ____ / ____ **Return Date:** ____ / ____ / ____

☐ **Denied** **Reason:** _____

_____

**Expanded Family and Medical Leave (EFMLEA)**

☐ **Approved** **Start Date:** ____ / ____ / ____ **Return Date:** ____ / ____ / ____

☐ **Denied** **Reason:** _____

_____

**Accommodation**

☐ **Approved** **Type of Accommodation Approved:** _____

_____

☐ **Denied** **Reason:** _____

_____

**Traditional FMLA Leave:**

☐ **Approved** **Start Date:** ____ / ____ / ____ **Return Date:** ____ / ____ / ____

☐ **Denied** **Reason:** _____

_____