EXHIBIT Descriptor Code: DDBE-E

FAMILIES FIRST CORONAVIRUS RESPONSE ACT LEAVE REQUEST FORM

Employees requesting emergency paid sick leave or expanded family and medical leave pursuant to the Families First Coronavirus Response Act (FFCRA) must complete this form in its entirety and submit as soon as practicable to the **Business Manager** upon completion.

Employee Name:	**Job Title:**
Phone:	**E-mail:**
Date of Request:	
Type of Leave Requesting: ☐ Emergency Paid Sick Leave ☐ Expanded Family and Medical Leave	
Anticipated Date of Leave:	**Expected Return to Work Date:**

Reason for Leave[1] (*check all applicable*) I am unable to work (or telecommute) for the following reasons:

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

Governmental entity ordering quarantine: ______________________

☐ I have been advised by a health care provider to self-quarantine related to COVID-19;

Health care provider advising quarantine: ______________________

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

☐ I am caring for an individual subject to an order described in (1) or self-quarantine as described in (2);

Name of individual: ______________________ *Relationship*: ______________________

☐ I am caring for a child whose school or place of care is closed or childcare provider is unavailable for reasons related to COVID-19; or

Name of child(ren): ______________________ *Age(s):* ______________________

Name of school, place of care or childcare provider: ______________________

Will another individual be providing care for your child(ren) during the period you are receiving expanded family and medical leave? ☐ *Yes* ☐ *No*

☐ I am experiencing a substantially-similar condition specified by the Secretary of Health and Human Services, in consultation with the Secretaries of Labor and Treasury.

Explain: ______________________

[1] Employees shall provide documentation such as a copy of any quarantine or isolation order, or written note by a health care provider advising self-quarantine, or a notice of closure of school or childcare provider (i.e. email, notification on website, or news article).

I will need *(choose one)*: ☐ Continuous leave ☐ Intermittent leave

If your need for leave is intermittent, please describe the nature of your intermittent leave:

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Substitution of Paid Leave: Employees may supplement emergency paid sick leave and expanded family and medical leave with any existing leave available to receive the full amount of the employee's regular salary.

I request to use the following existing paid leave during my FFCRA leave period (check all that apply):

☐ **Personal (____Hrs)** ☐ **Sick Leave (____Hrs)** ☐ **Other (____Hrs)]**

I certify that the above information is accurate and complete. I understand that if I fail to report for work on or before the scheduled return date indicated above or fail to contact my supervisor, regarding my absence from work beyond such scheduled date of return, my employer may take corrective action.

________________________________ ________________________________

Employee Signature Date

FOR OFFICE USE ONLY – DO NOT WRITE BELOW THIS SECTION	
☐ Approved ☐ Denied	Approved By: Date: