

FAMILIES FIRST CORONAVIRUS RELIEF ACT REQUEST FORM

FIRST NAME	MI	LAST NAME	DATE
DATE OF BIRTH		OFFICE LOCATION	
START DATE OF EMERGENCY LEAVE		NUMBER OF DAYS REQUESTED/END DATE	
		/	
EMPLOYEE STATUS	IF FULL TIME	IF PART TIME – AVG HOURS/WK	
<input type="checkbox"/> FT or <input type="checkbox"/> PT	<input type="checkbox"/> Salaried/Exempt <input type="checkbox"/> Salaried/Nonexempt <input type="checkbox"/> Hourly/Nonexempt	Average hour per week _____	

SECTION 1: EMERGENCY LEAVE REQUEST: Select A or B or A & B if applying for both

A. Emergency Paid Leave (EPL):

The company will provide paid leave for employees who are **unable to work or telework** as a result of a need for leave arising for any of the following reasons. The rate of pay for the paid leave depends on which of the following reasons the employee is taking the emergency leave.

*If choosing A - "Emergency Paid Leave", please check **ONE** primary valid reason for the request from below:*

- 1. The employee has been advised by a health care provider to self-quarantine due to concerns related to COVID-19;
- 2. The employee is experiencing symptoms of COVID-19 and seeking a medical diagnosis;
- 3. Caring for an individual who is subject to quarantine;
- 4. Caring for a son or daughter if the school or child-care provider is closed;
- 5. An employee's inability to work or telework while they are seeking or awaiting the results of a diagnostic test for, or a medical diagnosis of, COVID-19, when the employee has been exposed to COVID-19 or the employer has requested the test or diagnosis;
- 6. An employee's inability to work or telework while they are obtaining COVID-19 immunization; and
- 7. An employee's inability to work or telework while they are recovering from any injury, disability, illness, or condition related to COVID-19 immunization.

B. Expanded Family and Medical Leave (EFML):

Eligible employees will be able to take up to 12 weeks of leave for a "qualifying need related to a public health emergency". Such a need arises when an employee is **unable to work or telework** due the following reasons:

- 1. An employee's inability to work or telework due to any of the reasons outlined under the above emergency paid sick leave reasons; and
- 2. An employee's inability to work or telework due to a need to care for a son or daughter under the age of 18 years of age of such employee if the school or place of childcare has been closed, or
- 3. An employee's inability to work or telework if the childcare provider of such son or daughter is unavailable due to concerns related to COVID-19.

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SECTION 2: LEAVE DOCUMENTATION

Please provide the following information for the reason(s) identified above (respond only to the specific questions that are applicable to the reason(s) you checked above). Include all requested documentation as requested.

Note: The Company may request additional documentation, as needed.

1. Name and contact information of health care provider: _____
Start date for self quarantine: _____ End date for self quarantine: _____
Provide a copy of the self-quarantine or isolation order.
2. Indicate the COVID-19 symptoms you are experiencing: _____

Name and contact information of health care provider: _____
Date of next appointment with your health care provider: _____
3. Name and contact information of vaccine provider: _____
1st Appointment Date: _____ 2nd Appointment Date: _____
Provide a copy of the vaccine paperwork.
4. Name and contact information of provider for COVID-19 Testing: _____
Appointment Date for Test: _____
Provide a copy of the COVID-19 test results.
5. Name of person you are caring for: _____ Relationship: _____
Name and contact information of healthcare provider: _____
Is anyone else able to care for this person? ____ Yes or ____ No
Provide a copy of the quarantine or isolation order and/or a note from the healthcare provider.
6. Name(s) and age(s) of children: _____
Name and contact information of school, place of care or name of childcare provider: _____

Date when school or place of care is expected to be available: _____
Is anyone else able to care for the children? ____ Yes or ____ No
Are you interested in using your benefits intermittently: ____ Yes or ____ No
If yes, please provide your recommend schedule: _____
Provide a notice from the school(s) or childcare provider identifying its closure due to COVID-19.

I certify that all of the foregoing statements are true and correct to the best of my knowledge. I understand that misrepresentation or omission of facts may be cause for denial of leave and subject me to discipline up to and including termination.

Employee Signature _____ **Date** _____