FAMILIES FIRST CORONAVIRUS RELIEF ACT REQUEST FORM

FIRST NAME | MI | LAST NAME | DATE
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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

☐ FT or ☐ PT

☐ Salaried/Exempt
☐ Salaried/Nonexempt
☐ 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.
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 ___________________