Families First Coronavirus Relief Act
Leave Request Form

Paid Sick Leave

First Day of Leave: _____ Last Day of Leave: _____ # of Days: _____

Reason for Leave:

- ☐ Experiencing symptoms of COVID-19 and seeking a medical diagnosis ➞ paid at 100%, capped at $511 per day/$5,110 in the aggregate;
- ☐ Subject to a Federal, State, or local quarantine or has been told by a health care provider that he/she should self-quarantine due to COVID-19 ➞ paid at 100%, capped at $511 per day/$5,110 in the aggregate
- ☐ Assisting an individual who must quarantine/self-quarantine due to the above reasons ➞ paid at 2/3 the employee's rate, capped at $200 per day/$2,000 in the aggregate
- ☐ Caring for a son or daughter if his/her school/childcare provider is unavailable due to COVID-19 ➞ paid at 2/3 the employee's rate, capped at $200 per day/$2,000 in the aggregate
- ☐ Experiencing any other substantially similar condition specified by the Secretary of Health and Human Services ➞ paid at 2/3 the employee's rate and capped at $200 per day/ $2,000 in the aggregate.

Expanded Family Medical Leave Act Paid Leave

First Day of Leave: _____ Last Day of Leave: _____ # of Days: _____

Reason for Leave:

- ☐ Available to anyone after 30 days of employment for time to care for the employee's son or daughter, if the child's school/childcare provider is unavailable due to COVID-19 and the employee is unable to work (or telework). Subject to a two-week waiting period ➞ paid at 2/3 the employee's rate and capped at $200 per day/ $10,000 in the aggregate.

Employee Affidavit

I, _____, am requesting leave under the Families First Coronavirus Relief Act dated March 18, 2020. I certify that I am eligible for Paid Sick Leave and/or Expanded FMLA Paid Leave for the reason chosen above.

_____ _____

Employee's Signature *Date Signed*

Accepted by:

_____ _____

Employer Signature *Date Signed*