Families First Coronavirus Response Act (FFCRA)
Time Off Request Form

This form should be treated as a medical record and must be maintained in files separately from employees' files, in locked cabinets with only designated persons having access.

To be completed by employee:

Name: _____ Title: _____

Department: _____ Date: _____

I am requesting FFCRA leave for: ___ Paid Sick leave (or) _____Extended FMLA

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

If requesting leave for item (1), please provide documentation with the name of the gov. entity issuing the order

2 ☐ Have been advised by a health care provider to self-quarantine related to COVID-19

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

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

If requesting leave for item (2), (3) or (4), please provide Name, Address & Phone Number of health care provider issuing such advice.

Name of Health Care Provider: _____

Address of Health Care Provider: _____

Phone number of Health care Provider: _____

5 ☐ I am caring for my child whose school or place of care is closed (or child care provider is unavailable) due to COVID-19 related reasons.

6 ☐ Is experiencing any other substantially-similar condtion specified by the U.S. Department of Health and Human Services

If requesting leave for item (5), please provide Name of child; Name of school, place of care, or child care provider that has closed or become unavailable; and A statement that no other suitable person is available to care for your child.

Name of Child: _____

Name of School, Place of care (or) _____

Child Care provider: _____

Certified Statement "No other suitable person is available to care for my child" :

Certifying above statement: _____

Employee's signature

* *100% If applying for qualifying reasons #1-3 above, up to $511 daily and $5,110 total*
* *2/3 for quailfying reasons #4 & 6 above, up to $200 daily and $2,000 total*
* *Up to 12 weeks of Expanded FMLA paid at 2/3 for quailfying reasons #5 above, up to $200 daily and $12,000 total.*

If you are taking leave beyond the two weeks of emergency paid sick leave because your medical condition for COVID-19 related reasons rises to the level of a serious health condition, you must continue to provide medical certifications under FMLA.

Leave to begin_____ until approximately_____

Employee comments:

I certify that the above information is correct to the best of my knowledge.

Employee Signature:_____
(Date)

Name of person who completed form if other than employee:_____

For Employer Use:

Date Received

Receved By

Approved or Denied (if denied, explain why)

Employers Authorized Signature

Date