

EFRA LEAVE REQUEST FORM

Employee Name: _____

I certify that I am unable to work or telework because I ... (check one box and write in the dates for which leave is being requested)	Dates Requested
(A) am subject to a Federal, State, or local quarantine or isolation order related to COVID-19*;	
(B) have been advised by a health care provider to self-quarantine due to concerns related to COVID-19**;	
(C) am experiencing symptoms of COVID-19 and seeking a medical diagnosis***;	
(D) am caring for an individual who is subject to an order as described in paragraph (A) or has been advised as described in paragraph (B)****;	
(E) am experiencing a substantially similar condition to COVID-19 as specified by the Secretary of Health and Human Services in consultation with the Secretary of the Treasury and the Secretary of Labor*****; or	
(F) have to care for my under-18 son(s) and/or daughter(s) due to a school closure, place of care closure, or the unavailability of my child care provider due to the COVID-19 emergency*****.	

I understand that in addition to the above certification, I must also provide the following information in order to qualify for the requested leave:

* For reason (A), above, state the name of the government entity that issued the quarantine or isolation order: _____

** For reason (B), above, state the name of the health care provider who is advising the employee to self-quarantine due to concerns related to COVID-19: _____

*** For reason (C), above, state the name of the health care provider that the employee is contacting, has contacted, and/or from whom the employee is awaiting results: _____

**** For reason (D), above, state (1) the name of the individual, (2) the individual's relationship to the employee (e.g. spouse, roommate), and (3) either the name of the government entity that issued the quarantine or isolation order affecting the individual or the name of the health care provider who advised the individual to self-quarantine due to concerns related to COVID-19: _____

***** For reason (E), above, provide any information relating to a diagnosis, medical opinion, or setting forth the employee's condition/symptoms, such as a description of the symptoms and the name of the health care provider consulted (if applicable): _____

***** For reason (F), above, state (1) the name and age of the child/children being cared for and (2) the name of the school, place of care, or child care provider that is closed/unavailable. If the child is older than 14 and the leave requested is during the day, please explain what special circumstances require the leave. By signing below, I also certify that no other suitable person is available to care for the child/children so identified during the period of leave requested: _____

Employee Signature: _____ Date: _____

<p><i>Emergency Family and Medical Leave Expansion Act</i></p>			
	<p>the employee has worked for the employer at least 30 days and is unable to work or telework because he or she has to care for an under-18 son or daughter due to a school or place of care closure / the child care provider is unavailable due to the COVID-19 emergency</p>	<p>-up to 12 weeks total with the first ten days unpaid and the remaining 10 weeks (if the employee still qualifies) paid at 2/3 the employee's regular rate of pay (capped at \$200/day and \$10,000 in the aggregate)</p>	<p>-the employee's name; -signed statement that the employee is unable to work or telework due to a school or place of care closure / the child care provider is unavailable due to the COVID-19 emergency; -the date(s) for which leave is requested; and -(1) the name and age of the child/children being cared for, (2) the name of the school, place of care, or child care provider that is closed/unavailable, and (3) a statement representing that no other suitable person is available to care for the child/children during the period of leave requested (if the child is older than 14 and the leave requested is during the day, a statement explaining what special circumstances require the leave)</p>

**DOCUMENTATION NEEDED FOR QUALIFYING LEAVE UNDER THE
FAMILIES FIRST CORONAVIRUS RESPONSE ACT AND LEAVE REQUEST FORM**

Under the Families First Coronavirus Response Act ("FFCRA"), public employers are required to offer employees two new types of leave subject to certain qualifying terms and conditions. Recent guidance from the Department of Labor clarifies what documentation an employer should require for any leave request under the FFCRA. The documentation required serves a dual purpose: (1) it ensures that employees truly need the leave to which they may be entitled under the new law; and (2) it ensures that employers have the documentation needed to support any tax credit sought or taken as a result of providing leave under the FFCRA. Employers should maintain the records that they gather for FFCRA leave requests for four years.

The following table outlines the leaves available under the FFCRA and the types of documentation an employee should be asked to provide (and an employer should gather and retain) to provide evidence of the need for each of the qualifying circumstances:

FFCRA Leave Type Requested	Leave Length and Pay Required	Documentation Required
<p><i>Emergency Paid Sick Leave Act</i></p>	<p>-up to 80 hours of paid leave for full-time employees paid at 100% an employee's regular rate of pay (capped at \$511/day and \$5,110 in the aggregate)</p>	<p>-the employee's name; -signed statement that the employee is unable to work or telework due to a Federal, State, or local quarantine or isolation order related to COVID-19; -the date(s) for which leave is requested; and -the name of the government entity that issued the quarantine or isolation order</p>
<p>(1) the employee is subject to a Federal, State, or local quarantine or isolation order related to COVID-19</p>	<p>-up to 80 hours of paid leave for full-time employees paid at 100% an employee's regular rate of pay (capped at \$511/day and \$5,110 in the aggregate)</p>	<p>-the employee's name; -signed statement that the employee is unable to work or telework due to being advised by a health care provider to self-quarantine due to concerns related to COVID-19; -the date(s) for which leave is requested; and -the name of the health care provider who is advising the employee to self-quarantine due to concerns related to COVID-19</p>
<p>(2) the employee has been advised by a health care provider to self-quarantine due to concerns related to COVID-19</p>	<p>-up to 80 hours of paid leave for full-time employees paid at 100% an employee's regular rate of pay (capped at \$511/day and \$5,110 in the aggregate)</p>	<p>-the employee's name; -signed statement that the employee is unable to work or telework due to experiencing symptoms of COVID-19 and is seeking a medical diagnosis; -the date(s) for which leave is requested; and</p>
<p>(3) the employee is experiencing symptoms of COVID-19 and seeking a medical diagnosis</p>	<p>-up to 80 hours of paid leave for full-time employees paid at 100% an employee's regular rate of pay (capped at \$511/day and \$5,110 in the aggregate)</p>	<p>-the employee's name; -signed statement that the employee is unable to work or telework due to experiencing symptoms of COVID-19 and is seeking a medical diagnosis; -the date(s) for which leave is requested; and</p>

			<p>-documentation indicating that a medical diagnosis is being sought, such as the name of the health care provider that the employee is contacting, has contacted, and/or from whom the employee is awaiting results</p>
	<p>(4) the employee is caring for an individual who is subject to an order as described in subparagraph (1) or has been advised as described in subparagraph (2)</p>	<p>-up to 80 hours of paid leave for full-time employees paid at 2/3 an employee's regular rate of pay but cannot be less than applicable minimum wage laws (capped at \$200/day and \$2,000 in the aggregate)</p>	<p>-the employee's name; -signed statement that the employee is unable to work or telework due to caring for an individual who (1) is subject to a Federal, State, or local quarantine or isolation order related to COVID-19 or (2) has been advised by a health care provider to self-quarantine due to concerns related to COVID-19 (statement should include a description of the relationship to the individual); -the date(s) for which leave is requested; and -(1) the name of the individual, (2) their relationship to the employee, and (3) the name of the government entity that issued the quarantine or isolation order or the name of the health care provider who advised the individual to self-quarantine due to concerns related to COVID-19</p>
	<p>(5) the employee is caring for a son or daughter of such employee if the school or place of care of the son or daughter has been closed, or the child care provider of such son or daughter is unavailable, due to COVID-19 precautions</p>	<p>-up to 80 hours of paid leave for full-time employees paid at 2/3 an employee's regular rate of pay but cannot be less than applicable minimum wage laws (capped at \$200/day and \$2,000 in the aggregate)</p>	<p>-the employee's name; -signed statement that the employee is unable to work or telework due to a school or place of care closure / the child care provider is unavailable due to the COVID-19 emergency; -the date(s) for which leave is requested; and -(1) the name and age of the child/children being cared for, (2) the name of the school, place of care, or child care provider that is closed/unavailable, and (3) a statement representing that no other suitable person is available to care for the child/children during the period of leave requested (if the child is older than 14 and the leave requested is during the day, a statement explaining what special circumstances require the leave)</p>
	<p>(6) the employee is experiencing any other substantially similar condition specified by the Secretary of Health and Human Services in consultation with the Secretary of the Treasury and the Secretary of Labor</p>	<p>-up to 80 hours of paid leave for full-time employees paid at 2/3 an employee's regular rate of pay but cannot be less than applicable minimum wage laws (capped at \$200/day and \$2,000 in the aggregate)</p>	<p>-the employee's name; -signed statement that the employee is unable to work or telework because he or she is experiencing a substantially similar condition, as specified by HHS; -the date(s) for which leave is requested; and -any information relating to a diagnosis, medical opinion, or setting forth the employee's condition/symptoms, such as a description of the symptoms and the name of health care provider consulted (if applicable)</p>