**Employee Request for Leave under the Families First Coronavirus Response Act (FFCRA)**

**Name:** Click or tap here to enter text. **Personnel Number:** Click or tap here to enter text. **Date:** Click or tap here to enter text.

**DOA Section:** Click or tap here to enter text. **Dates Leave Requested:** Start Click or tap here to enter text. End: Click or tap here to enter text.

Under the FFCRA, you are unable to work if your employer has work for you to do, but one of the qualifying needs below prevents you from being able to perform that work, either at your regular worksite or by means of telework.

*By typing my initials here, I certify that I am unable to work or telework as defined by the FFCRA.* Click or tap here to enter text.

The FFCRA provides Emergency Paid Sick Leave (EPSL) and/or Expanded Family and Medical Leave Act (EFMLA) paid leave under specific qualifying needs related to COVID-19 upon the eligible employee’s request. Documentation may be required to verify eligibility, including name of the government entity ordering quarantine; or name of health care provider directing self-quarantine for you or the individual you are caring for (under qualifying needs 1, 2, 3, 4 and 6); or name and age of child being cared for, name of school or child care provider, and statement from you that no other suitable person is available to care for your child under qualifying need 5.

**Select the qualifying need for leave (please select only one):**

(1) You are subject to a Federal, State, or local quarantine or isolation order related to COVID-19. (EPSL)

(2) You have been advised by a health care provider to self-quarantine due to concerns related to COVID-19. (EPSL)

(3) You are experiencing symptoms of COVID-19 and seeking a medical diagnosis. (EPSL)

(4) You are caring for an individual who is subject to a quarantine or isolation order as described in item (1) above or have been advised by a health care provider to self-quarantine due to concerns related to COVID-19. (EPSL)

(5) You are caring for a son or daughter whose school or place of care has been closed or the child care provider is unavailable due to COVID-19 (EFMLA)

(6) You are 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. (EPSL)

**Select below how you want your pay to be calculated based on your qualifying need for leave (please select only one):**

OPTIONS FOR QUALIFYING NEEDS 1, 2 & 3 (Two Weeks/Max $511 per day):

Emergency Paid Sick Leave Only

Emergency Paid Sick Leave plus use of your available accrued leave to receive full regular pay

OPTIONS FOR QUALIFYING NEEDS 4, 5 & 6 (Two Weeks - including 1st two weeks of EFMLA - at 2/3 pay/ Max $200 per day)

Unpaid (will not reduce available EPSL or your available accrued leave)

Emergency Paid Sick Leave only (will not reduce your available accrued leave)

Employee’s own accrued leave only (will not reduce available EPSL)

Emergency Paid Sick Leave plus use of your available accrued leave to receive full regular pay

OPTIONS FOR QUALIFYING NEED 5 (Weeks 3-12 as available at 2/3 pay/Max $200 per day)

EFMLA only (will not reduce employee’s available accrued leave, limited to 2/3s of regular pay with $200 daily cap)

EFMLA plus use of your available accrued leave to receive full regular pay

If you elected to use your available accrued leave to receive full regular pay, indicate below which leave type you would like to use first, as allowed by Civil Service Rule 27, based on your own **available** accrued leave. : Annual Leave (LA), or Sick Leave (LB):

1st Used: Choose an item. 2nd Used: Choose an item.

If Compensatory Time (K) is available it will automatically be used before Annual Leave (LA) or Sick Leave (LB).

**HR USE ONLY**

Hourly Pay: Click or tap here to enter text. Hours Per Day: Click or tap here to enter text. Cap: Click or tap here to enter text.

**HOURS FOR ENTRY:**

**EPSL**

Daily EPSL Hrs: Click or tap here to enter text. All Daily Other Hrs (specify type(s)): Click or tap here to enter text.

**Required Documentation:** Name of entity ordering quarantine; or name of health care provider directing self-quarantine for employee or the individual an employee is caring for. Documentation Received: Yes  No

**EFMLA**

Daily EFMLA Hrs: Click or tap here to enter text. All Daily Other Hours (specify type(s)): Click or tap here to enter text.

Daily Quota Hrs: Click or tap here to enter text.

**Required Documentation:** Name of child being cared for, name of school or child care provider, and statement from employee that no other suitable person is available to care for the child. Documentation Received: Yes  No

**EE USE OF LB FIRST:** Must be approved by Appointing Authority. Notify Christina Cardona of request and maintain copy of approval, if granted, with other EE documents: Approval Granted & Documented: Yes  No