**[insert organization's logo, name and address]**

**[insert date]**

**[insert recipient's name]**

**[insert recipient's physical address (and/or email address if applicable)]**

Subject: Approval of leave request under the FFCRA

Dear **[insert recipient's name]**:

We have received and reviewed your request for **[insert emergency paid sick and/or expanded family and medical]** leave under the Families First Coronavirus Response Act (FFCRA), including your **[insert a description of any documentation provided by the employee, e.g., request for leave under the FFCRA, statement of the coronavirus-related reason the employee is requesting leave, and written support for that reason]**.

Based on the information provided, we have determined that your request qualifies for leave under the FFCRA and is approved.

Your FFCRA leave **[insert began or will begin]** on **[insert date]**. Your **[insert a description of the documentation provided by the employee]** indicates that you will need leave until **[insert date].**

You are eligible for up to **[insert number of hours or weeks]** of leave as outlined below.

**[insert one of the following provisions as applicable:**

**[Option 1 - if employee is taking emergency paid sick leave (for a reason other than their child's school or place of care being closed or child care provider being unavailable due to COVID-19-related reasons) and the employee is eligible for and requesting expanded family and medical leave:** Your FFCRA leave will be taken between **[insert dates]**.**]**

**OR**

**[Option 2 - if employee is taking both emergency paid sick leave and expanded family and medical leave because their child's school or place of care is closed or child care provider is unavailable due to COVID-19-related reasons:** Your leave will be taken concurrently between **[insert dates]**.**]]**

**[OPTIONAL for when the employer and employee agree to intermittent leave:** As agreed, you will take leave intermittently as follows: **[insert agreed upon schedule]**.**]**

You informed us that you need to take FFCRA leave because:

* (1) You are subject to a federal, state or local quarantine or isolation order related to COVID-19.
* (2) You have been advised by a health care provider to self-quarantine due to concerns related to COVID-19.
* (3) You are experiencing symptoms of COVID-19 *and* are seeking a medical diagnosis.
* (4) You are caring for a person who is subject to a federal, state or local quarantine or isolation order related to COVID-19 or has been advised by a health care provider to self-quarantine due to concerns related to COVID-19.
* (5) You are caring for your child/children whose school or place of care is closed or whose care provider is unavailable for reasons related to COVID-19.
* (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.

**[insert one of the following provisions as applicable:**

**[Option 1- if the qualifying reason for leave is #1, #2 or #3 above:** You are entitled to receive **[insert number]** hours of leave per day for up to two weeks (up to 80 hours) at your regular rate of pay capped at $511 per day, $5,110 total.**]**

**OR**

**[Option 2 - if the qualifying reason for leave is #4 and the employee is only seeking emergency paid sick leave, #5 or #6 above:** You are entitled to receive **[insert number]** hours of leave per day for up to two weeks (up to 80 hours) at two-thirds (2/3) your regular pay capped at $200 per day, $2,000 total.**]**

**OR**

**[Option 3 - if the qualifying reason for leave is #4 and the employee is only seeking expanded family and medical leave:** You are entitled to receive **[insert number]** hours of leave per day up to 12 weeks. The first 10 days are unpaid. After the first 10 days, you will be paid two-thirds (2/3) your regular pay capped at $200 per day, $10,000 total.**]**

**OR**

**[Option 4 - if the qualifying reason for leave is #4 and the employee is eligible for and seeking both paid sick leave and expanded family and medical leave:** You are entitled to receive **[insert number]** hours of leave per day for up to 12 weeks at two-thirds (2/3) your regular pay capped at $200 per day, $12,000 total.**]]**

**[insert for part-time employees:** Since you work part-time, your regular rate of pay represents your average number of hours per day over a two-week period.**]**

You may choose to use any existing paid time off, if applicable, to supplement the amount you receive, up to your normal wages.

Any group health insurance coverage that you participate in at the time of your leave request will continue under the same terms and conditions as if you continued to work.

If you have any questions on the above, please contact Human Resources **[or insert name/contact details for appropriate company representative or department]**.

**[insert closing (e.g., Sincerely, Very truly yours)]**,

**[insert handwritten signature (for a mailed letter) and typed signature]**

**[insert sender's title]**

**[insert enclosure line as applicable (e.g., Enclosure or Enclosures)]**

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