**PAID LEAVE REQUEST FORM**

Under the Families First Coronavirus Response Act   
as amended by the American Rescue Plan Act

EMPLOYER is voluntarily offering all employees the following paid leave (check all which apply):

[ ] 80 hours of paid sick leave\*

\**Notwithstanding any FFCRA paid sick leave taken prior to April 1, 2021, as of April 1 all employees may take up to 80 hours of paid sick leave for the reasons set forth below.*

[ ] 12 weeks of paid EFMLA

Please provide the information requested below and select which option you are requesting. You are required to substantiate your request with the specific information identified below. If you have any questions, please contact NAME OF COORDINATOR.

Employee’s name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date(s) for which leave is requested: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The COVID-19 related reason for which the employee is requesting leave:

[\_\_\_\_\_] **1.** You are subject to a federal, state or local quarantine or isolation order related to COVID-19 or you have been advised by a healthcare provider to self-quarantine. Please provide below the name of the governmental entity ordering quarantine or the name of the health care professional advising self-quarantine. You are eligible for up to 80 hours of paid sick leave at your regular hourly rate up to $511.00 per day.

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[\_\_\_\_\_] **2.** You are experiencing COVID-19 symptoms and seeking a diagnosis. You are eligible for up to 80 hours of paid sick leave at your regular hourly rate up to $511.00 per day. Specify your symptoms and the date upon which you sought a diagnosis.

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[\_\_\_\_\_] **3.** You are caring for an individual who is subject to quarantine or is self-quarantining. Specify the name of the individual for whom you are caring and that individual’s relation to you. Specify also the name of the governmental entity ordering quarantine or the name of the health care professional advising self-quarantine. You are eligible for up to 80 hours of paid sick leave at two-thirds your regular rate of pay, or up to $200.00 per day, whichever is less.

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[\_\_\_\_\_] **4.** You are caring for a child whose school or place of care is closed due to COVID-19. You are eligible for up to 80 hours of paid sick leave at two-thirds your regular rate of pay, or up to $200.00 per day, whichever is less. Specify below the name and age of the child (or children) to be cared for, the name of the school (or summer camp, summer enrichment program, or other summer program) that has closed or place of care that is unavailable, and a representation that no other person will be providing care for the child during the period of time for which the employee is requesting leave and, with respect to your inability to work or telework because of a need to provide care for a child older than fourteen during daylight hours, a statement that special circumstances exist requiring the employee to provide care.

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[\_\_\_\_\_] **5.** You are obtaining a COVID-19 immunization. You are eligible for up to 80 hours of paid sick leave at your regular hourly rate up to $511.00 per day. Please specify below the date upon which you are obtaining the immunization.

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[\_\_\_\_\_] **6.** You are recovering from an injury, disability, illness or condition related to the immunization (i.e., side effects of the vaccine). You are eligible for up to 80 hours of paid sick leave at your regular hourly rate up to $511.00 per day. Please specify below the date upon which you obtained the immunization.

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[\_\_\_\_\_] **7.** You are seeking or awaiting the result of a COVID-19 test or diagnosis because you have either been exposed to COVID-19 or your employer has requested the test or diagnosis. You are eligible for up to 80 hours of paid sick leave at your regular hourly rate up to $511.00 per day. Please specify below the date upon which you sought or will seek the test or diagnosis.

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**Paid EFMLA [only applicable if selected by the employer]**

\_\_\_\_\_ All employees who have been employed at EMPLOYER for at least 30 calendar days and are unable to telecommute due to any of the reasons set forth above are eligible for paid EFMLA. The rate of pay for EFMLA is two-thirds your regular rate of pay, or $200.00 per day, whichever is less. Please indicate which of the following as listed above (**1 – 7**) is the reason for which you seek the EFMLA and provide the supporting information.

Reason # \_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**ALL EMPLOYEES MUST COMPLETE THIS SECTION:**

Are you unable to work, including by means of telework, for the reason specified above? [ ] Yes [ ] No.

Please specify why you are so unable to work: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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By signing below, I certify that the information I have provided to EMPLOYER is true and accurate. I have included any supporting documentation, if available, along with this form.

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_