FAMILIES FIRST CORONAVIRUS RESPONSE ACT (FFCRA) LEAVE REQUEST FORM

This Act takes effect April 1, 2020. The leave under this Act does not accrue and expires December 31, 2020.

Employee Name: ______________________ Empl ID: ____________

Job Title: ______________________ Dept: ____________

An employee is entitled to FFCRA sick leave related to COVID-19 if the employee is still employed, if there is work to be performed, but the employee is unable to work or telework for one of the following reasons. **Please check the appropriate qualifying reason and answer the applicable questions:**

☐ **Emergency Paid Sick Leave (Self)** Dates of Leave: __________ to __________

Eligibility: First day of employment. Compensation: Up to 80 (hours or up to 10 days for Part-time employees based on average hours worked) of paid leave at regular rate of pay, to a maximum of $511/day and $5,110 total. Select one of the following:

☐ 1) I am unable to work due to a government-issued quarantine or isolation order.

☐ 2) I am unable to work due to direction to self-quarantine by a healthcare provider.

☐ 3) I am unable to work due to symptoms of COVID-19 and I am seeking diagnosis by a healthcare provider.(Medical certification may be requested).

☐ **Emergency Paid Sick Leave (Caregiver/Other)** Dates of Leave: __________ to __________

Eligibility: First day of employment. Compensation: Up to 80 hours (or up to 10 days for Part-time employees based on average hours worked) of paid leave at 2/3 of regular rate of pay, to a maximum of $200/day and $2,000 total. Select one of the following:

☐ 4) I am unable to work because I am the primary caregiver for someone with a COVID-19-related condition.
Name of Person Needing Care: ____________________ *Relationship:* ____________

☐ 5) I am unable to work because my dependent child's school or childcare is closed due to COVID-19.
Name(s) & age(s) of dependent children in household: ____________________
Name(s) of school(s) or childcare that is/are closed: ____________________

☐ 6) I am unable to work due to "a substantially similar condition", per the U.S. Dept of Health & Human Svcs.

☐ **Public Health Emergency Paid Family Leave** First 10 Days: __________ to __________
(Expanded family and medical leave for qualified reason #5) Dates of Paid Leave: __________ to __________

Eligibility: Employee must have been employed for at least 30 days. Compensation: First 10 days are paid under #5; remaining days up to an additional 10 weeks, are paid at 2/3 of regular pay, to a maximum of $200/day or $10,000 total.

There is no other suitable person available to care for my child. Yes ☐ No ☐

I hereby attest that I meet the criteria listed above and qualify for Emergency Paid Leave as I am unable to work, either at an assigned work site or in a remote assignment offered by Poway Unified.

FOR HR/PAYROLL USE	
HR Review	Date
Leave Entered By	Date

______________________ Employee Signature ____________ Date

______________________ Supervisor Signature ____________ Date

Employee: Complete and submit form to your Supervisor. Supervisor: Email completed form to COVID-19-HR@powayusd.com