

FFCRA LEAVE OF ABSENCE REQUEST

Name Robert Schroeder	Date 8.16.2020
Job Title Academic & Administrative Technology Coordinator	Department/Supervisor Service Desk / Ihab Saleh

TO BE COMPLETED BY EMPLOYEE:

A. I request a paid leave of absence under the Emergency Paid Sick Leave Act from 8.31.2020 to 10.02.2020 (insert dates). I am unable to work or telework because:

☐ 1. I am subject to a Federal, State, or local quarantine or isolation order related to COVID-19.

Governmental entity ordering quarantine or isolation: _____

☐ 2. I have been advised by a health care provider to self-quarantine due to concerns related to COVID-19.

Name of health care provider: _____

☐ 3. I am experiencing symptoms of COVID-19 and am seeking a medical diagnosis.

☐ 4. I am caring for an individual who is subject to a Federal, State, or local quarantine or isolation order related to COVID-19 or who has been advised by a health care provider to self-quarantine due to concerns related to COVID-19.

Name of individual and relationship to employee: _____

Governmental entity ordering quarantine or isolation: _____

☒ 5. I am caring for my son or daughter because my child's school or place of care has been closed, or the child care provider of my child is unavailable, due to COVID-19 precautions.

Name(s) and age(s) of child(ren): Makenna (6) & Bradley (10) Schroeder

Name of school and/or place of care: Sunrise Elementary School

☐ 6. I am 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.

B. I request approval for a paid leave of absence under the Emergency Family and Medical Leave Expansion Act from _____ to _____ (insert dates) because:

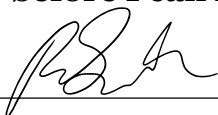
☐ 5. I am caring for my son or daughter because my child's school or place of care has been closed, or the child care provider of my child is unavailable, due to COVID-19 precautions.

LEAVES OTHER THAN THE ABOVE ARE NOT FFCRA ELIGIBLE

I understand that I can use my accrued sick and/or vacation time to off set the difference in pay for reasons 4, 5, and 6. Please circle yes or no; Employee will use sick and/or vacation - yes or no (circle one).

I understand that prior to any leave, I must make arrangements to continue insurance coverage if I am eligible. Further, I understand that I must contact HR and/or my supervisor before I can return to work.

Employee
Signature



Date 8.27.2020

❖ Completed form will be maintained in a confidential file, separate from your personnel file.

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C. Other information

If your leave is intermittent, please describe the nature of your intermittent leave:

If your child 15 years of age or older, please describe the special circumstances that exist requiring you to provide care:

If I am requesting leave because I am unable to work or telework due to the fact my child(ren)'s school or place of care has been closed due to COVID-19 reasons, by signing below I attest that special circumstances exist that require me to provide care and no other person will be providing care to the child during the period in which I receive family medical leave.

Employee
Signature  Date 8.27.2020

TO BE COMPLETED BY HUMAN RESOURCES:

Notes

(job restoration, maximum length, insurance, benefit accrual, service, review date, etc.)

Human Resources-Benefits Manager's Signature:

Eligible _____ Date _____

Ineligible _____ Date _____