STATE OF WEST VIRGINIA
APPLICATION FOR LEAVE UNDER THE FEDERAL FAMILIES FIRST CORONAVIRUS RESPONSE ACT/EMERGENCY FAMILY AND MEDICAL LEAVE and EMERGENCY PAID SICK LEAVE

(Note: Employee must be employed for 30 calendar days to be eligible for Emergency Family and Medical Leave)

EMPLOYEE NAME:	**WORK AND HOME TELEPHONE NUMBERS:**
EMPLOYEE ADDRESS: (Street Address, City and Zip Code)**:**	
AGENCY:	**SECTION:**

I AM MAKING APPLICATION FOR LEAVE UNDER THE FAMILIES FIRST CORONAVIRUS RESPONSE ACT FOR:

☐ **I AM UNABLE TO WORK OR TELEWORK**

EMERGENCY FAMILY AND MEDICAL LEAVE

☐ Care for a minor child if the child's school or place of child-care has been closed or is unavailable due to a public health emergency

1. Name and Age of Child (print) _____
   Name of school, place of child care, or child care provider _____
   School/Provider Phone Number:_____

2. Name and Age of Child (print) _____
   Name of school, place of child care, or child care provider _____
   School/Provider Phone Number:_____

3. Name and Age of Child (print) _____
   Name of school, place of child care, or child care provider _____
   School/Provider Phone Number:_____

**Please note information for additional children on a separate document and include with submission of this form.*

☐ ***Select if applicable***: Special circumstances exist that require that I provide care for an adult child older than eighteen.

I affirm that no other person is available to care for the child/ren during the period of requested leave:

_____
Employee Signature

I AM REQUESTING THE LEAVE BE PAID AND/OR UNPAID AS FOLLOWS:

____Hours Paid (annual) **____Hours Paid** (sick) **____Hours Paid** (emergency sick leave) **____Hours Unpaid**

NOTE: Eligible employees shall be granted unpaid leave or may take accrued leave, or up to 80 hours of paid emergency sick leave during the first ten (10) days of leave.

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EMERGENCY PAID SICK LEAVE:

☐ **SELF**

☐ I AM subject to federal, state or local quarantine or isolation order related to COVID- 19

Government entity that issued quarantine or isolation: _____

☐ I HAVE been advised by a health care provider to self-quarantine because of COVID-19

Health Care provider who advised to self quarantine: _____
Provider Phone Number:_____

☐ I AM experiencing symptoms of COVID-19 and seeking a medical diagnosis

NOTE: Full-time employees who are unable to work or telework are eligible for up to eighty (80) hours of paid sick leave at their regular rate of pay.

☐ **FAMILY MEMBER**

☐ I AM caring for an individual subject or advised to quarantine or isolation

Government entity that issued quarantine or isolation: _____

☐ I AM caring for a son or daughter whose school or place of care is closed, or child care provider is unavailable, due to COVID-19 precautions

1. Name and Age of Child (print) _____
   Name of school, place of child care, or child care provider_____
   School/Provider Phone Number:_____

2. Name and Age of Child (print) _____
   Name of school, place of child care, or child care provider_____
   School/Provider Phone Number:_____

3. Name and Age of Child (print) _____
   Name of school, place of child care, or child care provider_____
   School/Provider Phone Number:_____

☐ I AM experiencing substantially similar conditions as specified by the Secretary of Department of Health and Human Services

**Please note information for additional children on a separate document and include with submission of this form.*

☐ ***Select if applicable***: Special circumstances exist that require that I provide care for an adult child older than eighteen.

I AM REQUESTING THE LEAVE BE PAID AND/OR UNPAID AS FOLLOWS:

____**Hours Paid** (annual) ____**Hours Paid** (sick) ____**Hours Paid** (emergency sick leave) ____**Hours Unpaid**

NOTE: Full-time employees who are unable to work or telework are eligible for up to eighty (80) hours of paid sick leave at two-thirds (2/3) of the employee's regular rate or minimum wage, whichever is greater when caring for an immediate family member.

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PERIOD OF LEAVE: **FROM Date:**_____ _____ ☐ **AM** ☐ **PM** **TO Date:**_____ _____ ☐ **AM** ☐ **PM**	**TO BE TAKEN:** ☐ **Continuously** ☐ **Intermittently**
EMPLOYEE SIGNATURE:	**APPLICATION DATE:**
IMMEDIATE SUPERVISOR SIGNATURE: ☐ Approved ☐ Disapproved	**AGENCY AUTHORIZED SIGNATURE:** ☐ Approved ☐ Disapproved

NOTE: In response to the federal Families First Coronavirus Response Act effective April 1, 2020, and in accordance with the West Virginia Division of Personnel's (DOP) *Families First Coronavirus Response Act Policy* (DOP L-25), the DOP L-4A form is to be used by eligible employees affected by the COVID-19 pandemic to request leave for paid or unpaid leave under the Emergency Family and Medical Leave Expansion Act and the Emergency Paid Sick Leave Act. These provisions of the Act will be effective April 1, 2020. **An agency is required to retain all documentation provided pursuant to 29 CFR § 826.100 for four years, regardless whether leave was granted or denied. If an employee provided oral statements to support his or her request for emergency paid sick leave or expanded family and medical leave, the agency is required to document and maintain such information in its records for four years.**

For other qualifying leave under the federal Family and Medical Leave Act (FMLA), State Parental Leave Acts, leaves provided by the Division of Personnel's Administrative Rule W. VA. CODE R. §143-1-1 et seq., or any other leave afforded by state or federal laws, please see the current DOP L-1 through DOP L-12 forms.