Families First Coronavirus Response Act (FFCRA) Certification

(Complete and return to your Agency/Department Human Resources contact.)

Employee Name:	Employee ID#:
Department:	Classification:
Personal Phone#	Personal Email:
Name of Immediate Supervisor/Manager:	

SECTION 1

☐ **I am requesting Emergency Paid Sick Leave (EPSL) from _____ to _____.**

I certify that I am unable to work and am eligible for the requested leave because: *(check applicable box)*

☐ (1) I am subject to a Federal, State, or local quarantine or isolation order related to COVID-19.
- a. ☐ I am in isolation or quarantine due to illness/exposure to COVID-19 (quarantine start date_____).
- b. ☐ I am in a high-risk category (e.g. age 65+, underlying health conditions).
- c. ☐ I currently perform non-essential governmental functions and I am subject to a Shelter in Place Order and not yet assigned to other essential governmental work.

☐ (2) I have been advised by my health care provider to self-quarantine due to concerns related to COVID-19. Name of provider: _____.

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

☐ (4) I am caring for an individual who is subject to an order as described in (1) or (2). Name of provider advising quarantine of cared for individual: _____.

☐ (5) I am caring for my child, due to COVID-19 precautions, because my child's school has been closed, place of childcare has been closed, or childcare provider is unavailable, and no other suitable person will be caring for my child/children (Add name of child(ren) and School/Childcare Provider in Section 2 below).

☐ Intermittent Leave Requested. Frequency will be _____hours per day and/or _____days per week.

Note: *Intermittent leave only allowed for items (1) through (4) if Teleworking.*
Intermittent leave for item (5) allowed for either On-Site work or Telework.

SECTION 2

☐ **I am requesting Emergency Family and Medical Leave Expansion Act (EFMLEA).**
I certify that I am unable to work and am eligible for the requested leave based on the following:

☐ I am caring for my child; due to COVID-19 precautions because my child's school has been closed, place of childcare has been closed, or childcare provider is unavailable, and no other suitable person will be caring for my child(ren). Name of Child(ren): _____.

Name of School/Childcare Provider: _____Leave is from _____ through _____.

☐ Intermittent Leave Requested
If intermittent, the frequency will be _____hours per day and/or _____days per week.

☐ **I am <u>also</u> requesting Emergency Paid Sick Leave (EPSL) to pay for the first two (2) (unpaid) weeks of EFMLEA.**

Note: *The criteria provided herein is based on current information and is subject to change. This includes changes, due to revisions of federal, state or local law, regulation and/or regulatory agency guidance.*

SECTION 3 ***(Required for Processing)***

I request to supplement the ☐ EPSL ☐ EFMLEA with my own leave accruals ☐ Yes or ☐ No.

I hereby acknowledge that the above is true and correct. I understand that if my circumstances change, I must immediately inform my Agency/Department Human Resources contact.

_____ _____
Employee Signature Date

For Agency/Department HR use only:

☐ Approved ☐ Denied	Date:
Reviewer Name:	Reviewer Signature: