



**REQUEST FOR COVID-19 FAMILY AND MEDICAL EXPANDED LEAVE (FMLA) - EMPLOYER PAID UNDER THE FAMILIES
FIRST CORONAVIRUS ACT (FFCRA) – FORM A SIDE**

I am caring for my minor child, under age 18, because their school or daycare is closed, or the child’s care provider is unavailable because of COVID-19.

Has your supervisor made telework (work from home) available to you?

Yes (full telework) Yes (partial telework) No

If yes, you will be required to utilize the telework alternative prior to being approved for COVID-19 leave.

With supervisory approval, can your normal job duties be performed by working an alternate/split/or nontraditional schedule?

Yes No

_____ OR _____
Name of School Name of Daycare or Child Care Provider

Please list the approximate dates you are requesting off (up to a maximum of ten weeks):

____/____/____ to ____/____/____

Employee Signature

Date

Department Head

Human Resources Representative

COVID-19 Expanded FMLA Leave is:

Approved Denied

REQUEST FOR COVID-19 EMPLOYER PAID EMERGENCY SICK LEAVE UNDER THE FAMILIES FIRST CORONAVIRUS ACT (FFCRA) – FORM B SIDE

Employee Name: _____ Phone Number: _____

Department: _____ Position: _____

Reason for Request:

- I am subject to a federal, state, or local quarantine or isolation order related to COVID-19, **OR**, I have been advised by a health care provider to self-quarantine related to COVID-19, **OR** I am experiencing COVID-19 symptoms and am seeking a medical diagnosis.
- 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.
- I am caring for my minor child, under age 18, because their school or daycare is closed, or the child’s care provider is unavailable because of COVID-19.

Full time employees, please list the two consecutive weeks (up to 80 hours) you are requesting.

Part time employees, please list your scheduled hours over the two consecutive weeks you are requesting.

This does not need to be calendar weeks, but it does need to be consecutive. In the boxes below, **list specific dates and hours scheduled:**

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday

Name of health care provider or agency advising or requiring quarantine or isolation

Name of school, daycare or daycare provider if applicable

Employee signature

Date

Department Head

Human Resources Representative

COVID-19 Emergency Sick Leave is:

- Approved Denied