**REQUEST FOR LEAVE PURSUANT TO**

**FAMILIES FIRST CORONAVIRUS RESPONSE ACT (“the Act”)**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I am unable to work or telework and elect to take paid sick leave, at the rate established by the Act, from \_\_\_\_\_\_\_\_\_\_\_\_ until \_\_\_\_\_\_\_\_\_\_\_\_ (maximum of two weeks) for the following reason(s), checking all that apply and providing the requested information:

I am subject to a Federal, State, or local quarantine or isolation order related to COVID-19. If you select this reason for leave, please list the name of the governmental entity ordering quarantine or isolation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I have been advised by a health care provider to self-quarantine due to concerns related to COVID-19. If you select this reason for leave, please list the name of the health care provider advising self-quarantine related to COVID-19:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

I need to care for an individual who is subject to a Federal, State, or local quarantine or isolation order related to COVID-19 or has been advised by a health care provider to self-quarantine due to concerns related to COVID-19. If you select this reason for leave, please list in the spaces below (i) the name of the individual you need to care for, (ii) the relationship of that individual to you, and (iii) the name of the governmental entity ordering quarantine or isolation or, alternatively, the name of the health care provider advising self-quarantine of said individual.

Name of individual in need of care: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship of individual to you: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of governmental entity ordering quarantine or isolation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of health care provider advising self-quarantine: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I need to care for my child because his or her school or place of care has been closed, or his or her child care provider is unavailable, due to COVID-19 precautions. By selecting this reason for leave, I hereby certify that no other person will be providing care for my child (or children) during the period for which I am requesting leave. Further, if I am requesting leave during daylight hours to care for a child (or children) older than fourteen, I further certify that special circumstances exist requiring me to provide care to such child (or children). If you select this reason for leave, please list in the spaces below (i) the name and age of the child (or children) to be cared for, (ii) the name of the school or place of care that has closed or the child care provider who is unavailable, and (iii) if applicable, an explanation of any special circumstances that require you to need leave during daylight hours to care for a child (or children) older than fourteen:

Name and ages of children to be cared for by you: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of school, place of care, or child care provider that is closed or unavailable: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Special circumstances requiring you to care for child (or children) over fourteen: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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.

If you are requesting leave for the fifth reason leave listed above (i.e., caring for a child whose school or child care provider is closed or unavailable due to COVID-19), please also respond to the following:

At this time, I do / do not (circle one) wish to take additional leave from \_\_\_\_\_\_\_\_\_\_\_\_ until \_\_\_\_\_\_\_\_\_\_\_\_ (up to 10 weeks) for the fifth reason above, which I understand will be paid at the rate established by the Act.

If I wish to change these elections at any time, I will notify NAME, EMAIL at soon as practicable.

**By signing below, I hereby certify that the information provided by me on this form is true and correct. I understand that I must provide documentation to back the information I have provided in blanks above.**

Employee signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*The Company will not discipline, discharge or otherwise discriminate against any employee for his/her election to take leave under the Act.*