

**FAMILIES FIRST CORONAVIRUS RESPONSE ACT REQUEST FORM**

**Emergency Family Medical Leave (EFML) / Emergency Paid Sick Leave (EPSL)**

DATE:      \_\_\_\_\_\_\_\_\_\_\_ EMP TYPE: [ ]  Classified [ ]  Faculty [ ]  Exempt [ ]  Hourly/Student

SID #:      \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ NAME (Last, First):      \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DEPT:      \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SUPERVISOR:      \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PHONE #:      \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ EMAIL:      \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**EMERGENCY FAMILY MEDICAL LEAVE (EFML) QUALIFYING CONDITION:**

Up to 10 additional weeks (beyond EPSL period) of leave

1. **School/Child Care Closure**

[ ]  My minor child’s school, place of care, or child care provider is unavailable due to COVID-19 and I am unable to work as a result.

[ ]  My child(ren) are [list age/ages]:      \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ]  If older than 14, describe special circumstances:       \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ]  Written notice from my child’s school, place of care, or child care provider documenting the closure or unavailability due to COVID-19 is attached. (Notice can be in the form of a letter or email to you from an employee or official of the school, place of care or child care provider; a copy of a posting on a government, school, or day care website; or a copy of a publication about the closure in a newspaper.) **NOTE: documentation is not required prior to beginning leave.**

[ ]  No other suitable person can provide care for my child during the time I am requesting leave.

[ ]  My supervisor and I have discussed my telework options and have agreed to a reduced telework schedule due to my need to provide care for my minor child.

[ ]  My supervisor and I have discussed my telework options and have agreed that there are no telework options available for me.

[ ]  My employer presently has work available for me to do.

[ ]  I am unable to work at all due to childcare reasons and am requesting continuous leave until:      \_\_\_\_\_\_\_\_\_\_\_\_\_ (date)

**EMERGENCY PAID SICK LEAVE (EPSL) QUALIFYING CONDITION:**

Up to 2 weeks (80 hours) of leave (part-time employees will be prorated to a two-week equivalent)

1. **Isolation/Quarantine due to Federal, State or Local Order**

[ ]  I cannot perform work because of a federal, state or local quarantine or isolation order.

[ ]  My employer currently has work for me to perform, either at the workplace or remotely.

[ ]  Documentation of the isolation quarantine order will be provided. NOTE: documentation is not required prior to beginning leave. **(Note: Leave is not available if the employer does not have work for the employee to do, even if it is as a result of an isolation or quarantine order.)**

1. **Isolation/Quarantine by Health Care Provider**

[ ]  I have been advised by a health care provider,      \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, [insert name of health care provider] to self-quarantine due to concerns related to COVID-19 and as a result I am unable to perform the work my employer currently has available for me.

[ ]  Written documentation from the health care provider advising me to self-quarantine due to concerns related to COVID-19 will be provided. **NOTE: documentation is not required prior to beginning leave.**

[ ]  My employer presently has work available for me to do.

[ ]  My supervisor has confirmed there is no telework option available for me.

1. **COVID-19 Symptoms and Diagnosis**

[ ]  I am experiencing COVID-19 symptoms and seeking a medical diagnosis and as a result I am unable to work.

[ ]  My supervisor and I have discussed my telework abilities and have agreed to a reduced telework schedule so I can care for myself. (Note: intermittent leave under this reason can only be used for teleworking employees.)

[ ]  My employer presently has work available for me to do.

[ ]  My supervisor has confirmed there is no telework option available for me.

1. **Caring for an Individual in Isolation/Quarantine due to Federal, State or Local Order**

[ ]  I am caring for an individual who is subject to a federal, state, or local quarantine or isolation order related to COVID-19 and as a result I am unable to work.

[ ]  A copy of the Governor’s Stay Home-Stay Healthy Proclamation is attached.

[ ]  My supervisor and I have discussed my telework abilities and have agreed to a reduced telework schedule so I can care for the individual in quarantine/isolation. (Note: intermittent leave under this reason can only be used for teleworking employees.)

[ ]  My employer presently has work available for me to do.

[ ]  My supervisor has confirmed there is no telework option available for me.

1. **Caring for an Individual in Isolation/Quarantine by Health Care Provider**

[ ]  I am caring for an individual who has been advised by a health care provider,      \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, [insert name of health care provider] to self-quarantine due to concerns related to COVID-19 and as a result I am unable to work.

[ ]  Written documentation from the health care provider advising the individual to self-quarantine due to concerns related to COVID-19 will be provided. **NOTE: documentation is not required prior to beginning leave.**

[ ]  My supervisor and I have discussed my telework abilities and have agreed to a reduced telework schedule so I can care for the individual in quarantine/isolation. (Note: intermittent leave under this reason can only be used for teleworking employees.)

[ ]  My employer presently has work available for me to do.

[ ]  My supervisor has confirmed there is no telework option available for me.

**EXPECTED DATES OF LEAVE:** Begin Date:      \_\_\_\_\_\_\_\_\_ End Date:      \_\_\_\_\_\_\_\_\_\_\_\_

Will leave be taken intermittently?[ ]  YES [ ]  NO If so, on what schedule?       \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Additional Information:       \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**SUBMISSION:** Please sign (or indicate signature below if emailing submission) this form and route to HR at tmarker@wvc.edu.

I affirm that the foregoing is true and correct, and I understand that any misrepresentations provided as a basis for this request will be a basis for potential disciplinary action.

     \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_      \_\_\_\_\_\_\_\_\_      \_\_\_\_\_\_\_\_\_\_\_\_\_\_      \_\_\_\_\_\_\_\_\_\_

**Employee’s Signature Date Supervisor Signature Date**

HR ONLY:

Employment Date: \_\_\_\_\_\_\_\_\_\_ Received: \_\_\_\_\_\_\_\_\_\_\_ [ ]  EPSL Eligible [ ]  EFML Eligible [ ]  Not Eligible

Rev 10/2/20 tm