REQUEST FOR LEAVE UNDER THE FAMILY FIRST CORONAVIRUS RESPONSE ACT (FFCRA)
Please return this completed form via email or fax.

NAME: _________________________________________________ EMPLOYEE ID#:____________________

WORK LOCATION: _______________________________________

I am requesting leave because I am unable to work or work remotely beginning on _____________________
and continuing through ________________________ because:

Please select ONE (1) reason from below:

_____ 1. I am subject to a federal, state, or local quarantine/isolation order related to COVID-19

   ● Name of governmental entity ordering the quarantine/isolation: ________________________________
   ● Provide the date the quarantine/isolation order was recommended: ____________________________

_____ 2. I have been advised to self-quarantine by a health care provider due to concerns related to COVID-19; OR

_____ 3. I am experiencing symptoms of COVID-19 and seeking a medical diagnosis

   ● You must submit documentation from your healthcare provider including your (employee) name, dates of the
   requested leave and the COVID-19 qualifying reason for the leave.

_____ 4. I am caring for an individual who is subject to either reason 1 or 2 above

   ● Name of the individual you must care for and their relationship to you: __________________________

   ● Does the individual reside in your home: _____Yes    _____No
   ● For reason 1, identify the government entity ordering the quarantine/isolation:____________________
   ● Provide the date the quarantine/isolation order was recommended: ____________________________
   ● For reason 2, you must submit documentation from the individual’s health care provider including the individual’s name
   and the COVID-19 qualifying reason.

_____ 5. I am caring for my son or daughter whose primary or secondary school, or place of care, has been closed,
or my childcare provider is unavailable due to COVID-19 precautions. My son or daughter* is under age 18 (or age
18+ and has a mental or physical disability and is incapable of self-care due to the disability).

   ● Names and ages of all children needing care:____________________________________________________

   ● Name of school, place of care or child care provider that is closed due to COVID-19 (you must attach a copy of the
notice of closure you received from the school or child care provider) : ______________________________

☐ By checking this box, I confirm that no other person is available to provide care to the child(ren) listed above during the
period for which leave is requested.

CONTINUED ON NEXT PAGE
By signing below, you are certifying the above information is correct and that you are unable to work or work remotely during this leave period. Employee Health Services will contact you regarding the approval of your leave request and any additional information needed. You are expected to provide any necessary documentation within 15 days of submitting this request; please contact Employee Health Services if you need additional time.

_________________________________________________________
EMPLOYEE SIGNATURE

_________________________________________________________
DATE