COVID PAID SICK LEAVE AND COVID FMLA REQUEST FORM (formerly FFCRA)

Employee Name	Date	
Title	Supervisor	Department
Leave Start Date	Leave End Date	Total Hours Requested

I CERTIFY THAT AM UNABLE TO WORK (OR TELEWORK) FOR THE FOLLOWING REASON:

☐ I am subject to a **federal, state, or local quarantine or isolation** order related to COVID-19 that specifically prevents me from working.
Name of the government entity issuing the order: _____

☐ I have been **advised by a health care provider to self-quarantine** because of concerns related to COVID-19.
Name of the advising healthcare provider: _____

☐ I have **symptoms of COVID-19** and I am seeking (or have sought) a diagnosis.

☐ I am **caring for another individual** who is subject to quarantine or has been advised by a health care provider to self-quarantine related to COVID-19.
Name of person I am caring for and our relationship:

Name of the government entity issuing the order: _____

OR

Name of the advising healthcare provider: _____

☐ I **need to care for my child(ren)** because their school or childcare provider is closed or unavailable because of COVID-19. **I certify that no other suitable person is available to care for the child(ren) during the period of requested leave.** If listed child is over 14, I further certify that there are special circumstances that require me to provide care for them.

Name(s) and age(s) of child(ren): _____

Name of closed school(s) or place(s) of care: _____

I certify that the above information is truthful and understand that misrepresenting my need for leave is grounds for discipline, up to and including termination.

Employee Signature: _____

If signing electronically, please type your full name, followed by "e-signed.":

_____