**REQUEST FOR**

# Leave Related to COVID-19

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Dates of Leave ____________________________ Leave No. ___________________

Name___________________________________ Building/Dept. _______________

***This request is for:***

My Own COVID Symptoms

Leave Available:

Sick leave Dates: ________________________________

Personal Incentive Vacation Dates: ________________________________

Emergency paid sick leave under FFCRA/EPSLA (10 days up to $511/day) Dates: _______________

May be eligible for 12 weeks total per year of PFML and FMLA (paid or unpaid depending on individual circumstances). Dates: ________________________________

Quarantined Due to Exposure

Leave Available for Non Job Related Exposure:

Sick leave Dates: ________________________________

Personal Incentive Vacation Dates: ________________________________

Emergency paid sick leave under FFCRA/EPSLA (10 days up to $511/day) Dates: _______________

Leave Available for Job Related Exposure:

Paid Administrative Leave Dates: ________________________________

Caring for Family Member with COVID

Leave Available:

Sick leave Dates: ________________________________

Personal Incentive Vacation Dates: ________________________________

Emergency paid sick leave under FFCRA/EPSLA (10 days *at 2/3 pay*, up to $200/day)

Dates: ________________________________

May be eligible for 12 weeks total per year of PFML and FMLA to care for family member with a serious health condition (paid or unpaid depending on individual circumstances).

Dates: ________________________________

Leave Due to Being High Risk

Leave Available:

Sick leave Dates: ________________________________

Personal Incentive Vacation Dates: ________________________________

Emergency paid sick leave under FFCRA/EPSLA (10 days up to $511/day) *if advised by a healthcare provider to self-quarantine due to being particularly vulnerable to COVID.

Dates: ________________________________

May be eligible for 12 weeks total per year of PFML and FMLA (paid or unpaid depending on individual circumstances). Dates: ________________________________

Leave Due to High Risk Person in My Household

Leave Available:

Personal Incentive Vacation Dates: ________________________________

Emergency paid sick leave under FFCRA/EPSLA (10 days at 2/3 pay up to $200/day) “caring for an individual who has been advised to self-quarantine due to being particularly vulnerable”.

Dates: ________________________________

Leave Due to Care for My Child Due to School or Childcare Closure

Leave Available:

EPSLA Dates: ________________________________

EFMLA Dates: ________________________________

***For medical leave, you must attach a medical certification statement from your (or your family member’s) health care provider indicating that a serious health condition exists.***

**INSURANCE COVERAGE:**

*I understand that my health care coverage will remain in effect during FMLA, if eligible. Otherwise, insurance eligibility is determined by the School Employees Benefits Board (SEBB).*

Employee’s Signature_____________________________________________ Date:__________________

Supervisor’s Signature_____________________________________________Date:__________________

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**DISTRICT APPROVAL FOR**

## FMLA/WFC/FFCRA/EPSLA

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☐ Leave Approved:

- ☐ Sick leave Dates: ________________________
- ☐ Personal ☐ Incentive ☐ Vacation Dates: ________________________
- ☐ EPSLA Dates: ________________________
- ☐ FMLA Dates: ________________________

**NOTE to EMPLOYEE*: You are expected to notify your immediate supervisor if the day of your return to work will be different from the date referenced above. We will then re-evaluate your employment status.***

_____________________________________________ _________________________________

Director of Human Resources or Designee Date

☐ Leave dates updated:

New dates:________________________________ Approved:____________________ Date:____________

New dates:________________________________ Approved:____________________ Date:____________

New dates:________________________________ Approved:____________________ Date:____________

NOTE: Eligibility Dates for FMLA (if needed, and if consecutive): ______________________________________