FILE: GBC-E-3

**Family First Coronavirus Relief Act (FFCRA) Emergency Paid Sick Leave Form**

**There are four steps in applying for a leave:**

1. Check the Staff Member Leave Policy GBC to be sure your leave is consistent with the “COVID-19 Related Time Off and Leave Types” guidelines.
2. Contact your supervisor to discuss your request for leave.
3. Contact Human Resources to receive information regarding this requested leave.

Last First MI Date

Last Name First Name MI Date

Address City State Zip

Home Street Address City State Zip

Phone Email

Best Contact Phone Number Home Email

Building Position

Work Location(s) Position(s)

***Emergency Paid Staff Leave is a separate allocation of paid staff leave for a qualifying reason. This leave may not be used for any additional reason and unused hours will not be paid out. EPSL is not retroactive to qualifying events before the April 1, 2020 effective date. Any leaves granted under the EPSL will expire with the expiration of the Families First Coronavirus Relief Act on December 31, 2020.***

**­Emergency Paid Sick Leave under the Families First Coronavirus Relief Act (EPSL)** (two weeks – up to 80 hours) \*

* *Documentation from a Health Care provider should be attached, if possible. The Health Care Provider’s Statement Form (WPSD 2) may be used for this purpose but is not required if other documentation from the Health Care Provider is submitted*.

**Reason:**

Under the FFCRA, a staff member qualifies for paid sick time (full pay for reasons 1-3, 2/3 pay for 4-6) if the staff member is unable to work **(or unable to work remotely)** due to a need for leave because the staff member: ­

1. is subject to a Federal, State, or local quarantine or isolation order related to COVID-19; ­
2. has been advised by a health care provider to self-quarantine related to COVID-19; ­
3. is experiencing COVID-19 symptoms and is seeking a medical diagnosis; ­
4. is caring for an individual subject to an order described in (1) or self-quarantine as described in (2); ­
5. is caring for a child whose school or place of care is closed (or childcare provider is unavailable) for reasons related to COVID-19; or ­
6. is experiencing any other substantially-similar condition specified by the Secretary of Health and Human Services, in consultation with the Secretaries of Labor and Treasury.

**Approximate Dates** From: Date To: Date

**Extension of previously approved leave (if applicable)** From: Date To: Date

***\* Your leave request may qualify you for specific benefits under the Family and Medical Leave Act (FMLA) and Expanded Family and Medical Leave Act. A final determination of FMLA qualification will be made after review of your completed Leave Request Form and Health Care Provider’s Statement or other documentation.***

**The signatories below certify that this leave request is in accordance with Woodland Park School District Re-2 Staff Leave Policy and Procedure.**

Staff Member’s Signature Date

Principal/Supervisor’s Signature Date

Review/Approval by Director for Human Resources Date

**Family First Coronavirus Relief Act (FFCRA) Emergency Paid Sick Leave Form**

**Staff Member Statement Supporting Leave**

I, Full Name , provide the following information in support of my request for emergency paid sick leave (complete all that apply):

**Leave due to a government-issued quarantine or isolation order:**

Name of the issuing government agency for the quarantine or isolation order:

Name of Agency

**Effective dates of the order:** From: Date. To: Date.

**Leave due to health care provider’s advice to self-quarantine:**

Contact information for the health care provider advising me or the individual I am caring for to self-quarantine:

Name: Name Phone: Phone Fax: Fax

Written documentation is available and attached: Yes No

Name and relation of the individual who I am needed to care for:

Name: Name Relation: Relationship

**Effective dates:** From: Date To: Date.

**Leave due to a school or place of child-care closed due to COVID-19:**

Name of school, place of care, or child caregiver unavailable due to concerns related to COVID-19:

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

Name and age of child or children I am needed to care for:

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_\_\_\_

No other suitable person is available to care for my child(ren) for the requested leave period due to:

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

The special circumstances requiring my need for leave to care for a child ages 15-17 are:

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

**Effective dates:** From: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ To: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Leave due to substantially similar conditions specified by the Secretary of Health and Human Services:**

Provide details regarding the need for this leave:

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

**Effective dates of the order:**  From: Date To: Date

**I attest that the above information is accurate and complete. I understand falsification of any information given may lead to disciplinary action.**

**Staff Member Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**