FILE: GBC-E-3

 **Healthy Families Workplace Act (HFWA) Supplemental Leave Form**

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

1. Check the Staff Member Leave Policy GBC. When supplemental leave is four or more days, reasonable documentation may be required.
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)

***Healthy Families Workplace Act Supplemental 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. HFWA Supplemental Leave is not retroactive to qualifying events before the January 1, 2021 effective date. Any leaves granted under the HFWA will expire four weeks after the official termination or suspension of the public health emergency.***

**­Supplemental Leave under the HFWA** (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 HFWA, a staff member qualifies for paid sick time if the staff member is unable to work due to a need for leave because the staff member: ­

1. Self-isolation or seeking medical care or treatment due to a diagnosis or symptoms of a communicable illness that is the cause of a public emergency; ­
2. Caring for a family member who is self-isolating or seeking medical care after being diagnosed or is experiencing symptoms of a communicable illness that is the cause of a public health emergency; ­
3. A determination from a local, state, or federal public official or health authority that a staff member or a member of the staff member’s family that the staff member cares poses a risk to the health of others; ­
4. Caring for a family member when the individual’s school or place of care has been physically closed due to a public health emergency; or ­
5. A staff member’s inability to work because of a health condition that may increase susceptibility to or risk of a communicable illness that is the cause of a public health emergency

 **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 Healthy Families Workplace Act Supplemental Leave. 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.***

***\*\* Supplemental Leave granted under the EPSL provision of the FFCRA will be considered used HFWA Supplemental Leave if granted before December 31, 2020.***

**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

**Healthy Families Workplace Act (HFWA) Supplemental Leave Form**

**Staff Member Statement Supporting Leave**

I, Full Name , provide the following information in support of my request for supplemental 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 public health emergency:**

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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**