COVID-19 Related Absence Report (FFCRA)

INSTRUCTIONS: Use this form to request leave under the Emergency Paid Sick Leave Act (EPSLA) and/or Emergency Family and Medical Leave Expansion Act (EFMLEA) as part of the Families First Coronavirus Response Act. Submit the completed form and supporting documentation. Please review the Employee Rights FFCRA poster for more information about the benefits you may be eligible to receive.

NAME:	DATE:
JOB TITLE:	SCHOOL:
LEAVE START:	LEAVE END:

Indicate total amount of time absent (Full Day(s) or Total Number of Hours): ___________________________

REASON FOR LEAVE

Emergency Paid Sick Leave (EPSL)

☐ I am requesting EPSL and am unable to work, including telework and/or working remotely, for the following reason (SELECT ONLY ONE OPTION BELOW):

☐ 1. I am subject to a local, state or federal quarantine order due to COVID-19 (SELF)
Governmental agency ordering the isolation order:_______________________________________

☐ 2. I have been advised by a health care provider to self-quarantine due to COVID-19 (SELF)
Name of Healthcare provider:_______________________________________

☐ 3. I am seeking medical diagnosis for COVID-19 related symptoms (SELF)

☐ 4. I am caring for an individual subject to a quarantine order from a local, state or federal entity OR as advised by a health care provider due to concerns related to COVID-19
Name of individual and relationship to employee: _______________________________________
Governmental agency ordering the isolation order:_______________________________________ **OR**
Name of Health care provider:_______________________________________

☐ 5. Caring for my child whose schools or place of care is CLOSED (or child care provider is unavailable) due to COVID-19 related reasons
Name(s) and age(s) of Child(ren): _______________________________________
Name of school and/or place of care:_______________________________________

☐ 6. Experiencing other substantially similar condition specified by the U.S. DHHS
Explain: _______________________________________

Note: The EPSLA provides up to 80 hours of paid time for full-time employees (part-time employees receive the equivalent of 2 weeks of pay).
FOR REASONS 1-3 ABOVE: Employees will be paid their regular rate of pay up to a daily cap of $511 and $5,110 in the aggregate. FOR REASONS 4-6 ABOVE: Employees will be paid at 2/3 their regular rate of pay up to a daily cap of $200 and $2,000 in the aggrigate.

USE OF PAID TIME OFF TO SUPPLEMENT EPSL BENEFITS: If my pay during EPSL (reasons 4-6 above) is less than my regular rate of pay, I elect to use the following accrued paid leave available to supplement my EPSL benefit up to my regular rate of pay:

☐ Sick Leave ☐ Vacation Time ☐ Personal Time *if applicable ☐ I do not wish to use paid leave

NOTE: SUPPORTING DOCUMENTATION IS REQUIRED

Emergency Family Medical Leave Expansion Act (EFMLEA)

☐ I am requesting EFMLEA leave because I and am unable to work, including telework and/or working remotely, due to caring for my child whose schools or place of care is CLOSED (or child care provider is unavailable) due to COVID-19 related reasons.

Name(s) and age(s) of Child(ren): ____________________

Name of school and/or place of care: ____________________

SUBSTITUTION OF PAID LEAVE: Pursuant to the FFCRA, the first 10 days of your EFMLEA are unpaid. However you may be eligible to utilize EPSL or any applicable accrued paid time off. Please indicate below what paid leave, if any, you wish to utilize during your EFMLEA:

☐ PTO __________(hours/ days) ☐ EPSL __________(hours/ days) ☐ I do not wish to use paid leave

Note: Employees are eligible for EFMLEA leave if they have been employed for at least 30 days with the District and have not already exhausted their 12 week FMLA entitlement. Leave under EFMLEA is paid at 2/3 their regular rate of pay up to a daily cap of $200 and $10,000 in the aggregate.

USE OF PAID TIME OFF TO SUPPLEMENT EFMEA BENEFITS: I elect to use the following accrued paid leave available to supplement my EPSL benefit up to my regular rate of pay:

☐ Sick Leave ☐ Vacation Time ☐ Personal Time *if applicable ☐ I do not wish to use paid leave

EMPLOYEE CERTIFICATION: I certify that the information I have provided in this form, including the reason I need leave and information provided in support of my need for leave is truthful and accurate. I further certify that if I am taking EFMLEA or EPSL for reason #5, that no other suitable person will be caring for my child during the period for which I take this leave. If this changes, I agree to promptly notify the SAU#9 office.

Employee Signature:____________________ Date: ______________

Signature of Principal/Supervisor: ____________________ Date: ______________

Comments: ____________________

FOR SAU9 OFFICE USE ONLY

DESIGNATION

LEAVE TYPE	APPROVED	DENIED
☐ **Emergency Paid Sick Leave**	Total Amount of Time Designated: ______________ ☐ Full Pay ☐ 2/3 Pay	___ EPSL Already Exhausted ___ Not Applicable for EPSL ___ Other
☐ **Emergency Family and Medical Leave Expansion Act**	Total Amount of Time Designated: ______________ ☐ 2/3 Pay	___ EFMLEA Already Exhausted ___ Not Applicable for EPSL ___ Other
☐ **OTHER**	___ Approved Administrative Leave due to COVID-19 ___ Approved Flex Work due to COVID-19 ___ Sick Leave ___ Other: ____________________	

Signature of Superintendent: ____________________ Date: ______________