Families First Coronavirus Response Act Paid Leave
Employee Leave Election Form

To: [Insert HR Contact Details]

Employee Name: _____

Contact Information (email and phone): _____

SECTION 1: Identify the reason(s) under the Families First Coronavirus Response Act (FFCRA) for which you are unable to work or perform telework and are requesting paid leave:

1. ☐ I am subject to a federal, state, or local quarantine or isolation order related to COVID-19.

2. ☐ I have been advised by a health care provider to self-quarantine related to COVID 19.

3. ☐ I am experiencing COVID-19 symptoms and am seeking a medical diagnosis.

4. ☐ I am caring for an individual subject to a federal, state or local quarantine or isolation order related to COVID-19 or who has been advised by a healthcare provider to self-quarantine related to COVID-19.

5. ☐ I am caring for my child whose school or place of care is closed (or childcare provider is unavailable) for reasons related to COVID-19.

6. ☐ Other reason: _____
_____
_____

SECTION 2: Please provide the following information for the reason(s) identified in numbers 1 through 6 above (respond only to the specific numbers that you checked above). Include all requested documentation. The Company may request additional documentation supporting your request for paid leave, as needed.

1. Identify the government authority that issued the isolation order: _____
_____
Are you able to perform your duties via telework? ___ Yes ___ No
Please include a copy of the quarantine or isolation order together with your request.

2. Name and contact information of healthcare provider: _____
Beginning and end dates you have been instructed to self-quarantine: _____
Please provide a note from your healthcare provider together with your request.

3. The COVID-19 symptoms you are experiencing include: _____
Name and contact information of healthcare provider: _____
Date of next appointment with your healthcare provider: _____

4. Name and relationship to person you are caring for: _____
Name and contact information of healthcare provider (if applicable): _____

Is anyone else able to care for this person? _____
Please include a copy of the quarantine or isolation order, or a note from the healthcare provider, together with your request.

5. Name(s) and age(s) of children: _____
Name and contact information of school, place of care, or name of childcare provider:

_____

Date when school or place of care is expected to be available: _____
Please include a notice from your school or childcare provider identifying its closure, together with your request.

Will you need leave to care for your child for longer than 10 days? ___ Yes ___ No

For the first ten days of leave to care for your child, do you want to utilize FFCRA paid sick leave, PTO or be unpaid? ___ Utilize Sick Leave ___ Utilize PTO ___ Unpaid

6. Nature of condition: _____

SECTION 3: Describe the duration and dates for which you are requesting FFCRA leave:

_____

_____

I certify that all of the foregoing statements are true and correct to the best of my knowledge. I understand that misrepresentation or omission of facts may be cause for denial of leave and subject me to discipline, up to and including termination.

Signature: _____

Date: _____

_____

FOR PERSONNEL OFFICE USE ONLY
After processing election form, place in employee's personnel file and return a copy to employee.

Date Leave Election Form Received: _____

Reviewed By: _____

☐ Employee's leave request is approved, as follows: _____

_____

If employee is taking leave for reason number 5, complete a separate FMLA designation form.

☐ Employee's leave request is denied. Reason: _____

_____