FAMILY FIRST CORONAVIRUS RESPONSE ACT FORM

To apply for a leave under FFCRA, please complete the information below and return to:
Randi Libby at rlibby@wanee.org

Section A: Employee Information

Name: _____ Hire Date: _____

Employment Type: ☐Full time ☐ Part time ☐ Other: _____

Address: _____

Phone Number: _____ Email: _____

Section B: Leave of Absence General Information

Leave of Absence Start Date: _____ Leave of Absence End Date: _____

Are you able to perform your work from home? ☑Yes ☐ No

Briefly describe the reason for your leave of absence request:

_____

_____

Section C: Leave of Absence Details

Please select one of the six options below and provide the requested details.

☐ 1. You are subject to a Federal, State, or local quarantine or isolation order related to COVID–19.

Please provide the name of the governmental entity ordering the quarantine: _____

☐ **2. You have been advised by a health care provider to self-quarantine due to concerns related to COVID–19.**

Please provide the name of the health care provider advising the self-quarantine: _____

☐ **3. You are experiencing symptoms of COVID–19 and seeking a medical diagnosis.**

☐ **4. You are caring for an individual who:** is subject to a Federal, State, or local quarantine or isolation order related to COVID–19.

Please provide the name of the governmental entity ordering the quarantine: _____

Name of the individual you are caring for: _____

Their relationship to you: _____

☐ **5. You are caring for a son or daughter because the school or place of care has been closed, or the childcare provider is unavailable, due to COVID–19 precautions.**

A. Will you be the only person providing care during the period for which you are requesting leave? ☐Yes ☑ No

B. The first two weeks of this type of leave are unpaid, but you can use your Paid Sick Time provided under the Families First Coronavirus Response Act (FFCRA), use other accrued time (vacation, PTO, etc.), or take the time unpaid. Please identify how you would like to be paid during the first two weeks of your leave:

☐ Use my FFCRA Paid Sick Time.

☐ Use other accrued time. Please describe: _____

☐ Take the time unpaid.

C. School/Facility Information:

Name of the school or facility: _____

D. Please provide the following information about each child:

_____

Name Age Relationship to you

_____

Name Age Relationship to you

_____

Name Age Relationship to you

_____

Name Age Relationship to you

If any of your children are over the age of 14 and you will be providing care during daytime hours, please describe the special circumstances that exist that require your care:

_____

_____

☐ **6. You are experiencing any other substantially similar condition specified by the Secretary of Health and Human Services in consultation with the Secretary of the Treasury and the Secretary of Labor.**

Please describe the circumstances:

_____

_____

I certify that all of the foregoing statements are true and correct to the best of my ability. I understand that misrepresentation or omission of facts may be cause for denial of leave and subject to other policies through my employer, including attendance and honesty & ethics policies.

_____ _____

Employee Signature **Date**