Families First Coronavirus Response Act (FFCRA)

Emergency Paid Sick Leave Request Form

EMPLOYEE'S NAME:____Last 4 digits of SOCIAL SECURITY #: _____________

Home/Cell PHONE#:______________________DEPT/BUREAU:___________________SUPERVISOR: ___________________

Please check the reason for leave:

	1. Employee is subject to a quarantine or isolation order related to COVID-19 Name of government/agency issuing order:___________________________________
	2. Employee advised by a health care provider to self-quarantine because of COVID-19. List name of health care provider advising self-quarantine: Provider's Name: ___________________________________
	3. Employee is experiencing symptoms of COVID-19 and is seeking a medical diagnosis
	4. Employee is caring for an individual subject or advised to quarantine or isolation. Provide Name & Relationship of individual employee is caring for: Name:__________________________ Relationship:________________
	5. Employee is caring for a son or daughter whose school or place of care is closed, or child care provider is unavailable, due to COVID-19 precaution. Name of school or child care center/provider: ____ ______________________________ ______________________________ Child's Name Birth Date Child's Name Birth Date ______________________________ ______________________________ Child's Name Birth Date Child's Name Birth Date Employee attests that no other person will be providing care for the child(ren) during the requested Emergency Paid Sick Leave period ______ (Employee Initials) For child(ren) older than fourteen, provide information on special circumstances that require employee to provide care during daylight hours. ____
	6. Employee is experiencing any other substantially-similar condition specified by the U.S. Dept. of Health & Human Services

Note: For full-time employees, paid leave for reasons #1-3 above is limited to 100% of pay not to exceed $511 daily for 10 days. For full-time employees, paid leave for reasons #4-6 above is limited to 2/3rds of pay not to exceed $200 daily for 10 days. (Reduced amounts for part-time employees.) Use the Expanded FMLA Request Form for Covid-19 related child care leave beyond 10 days.

Type of Absence Requested:

Full-Time Absence (10 day Max) Start Date:________________ End Date:__________________

Intermittent Absences (80 hour Max for FT employees) Start Date:____________ End Date:______________

I request to use my accrued leave to supplement the Emergency Paid Sick Leave YES NO

EMPLOYEE'S SIGNATURE: _________________________________DATE:___________________________

Supervisor/Dept Head Section:

Is employee eligible for telework? YES NO

Is employee unable to work, including telework, for one of the reasons listed above? YES NO

Employees who are eligible & able to telework despite one of the reasons listed above are not eligible for Emergency Paid Sick Leave

_____________________________ _______________________________ ____ _______
Supervisor Signature Supervisor Printed Name Ext Date

DEPARTMENT HEAD SIGNATURE_______________________________ DATE: ____________

Dept Head Printed Name ____

Return completed form to Human Resources or email to kgerald@howardcountymd.gov