KENTFIELD SCHOOL DISTRICT FFCRA LEAVE REQUEST FORM

The Families First Coronavirus Response Act (FFCRA) requires certain employers to provide their employees with paid sick leave and expanded family and medical leave for specified reasons related to COVID-19. These provisions will apply from April 1, 2020 through December 31, 2020.

Paid Leave Entitlements

Up to two weeks (80 hours, or a part-time employee's two-week equivalent) of paid sick leave based on their regular rate of pay paid at:

- 100% for qualifying reasons #1-3 below, up to $511 daily and $5,110 total;
- 2/3 for qualifying reasons #4 and #6 below, up to $200 daily and $2,000 total; and
- Up to 12 weeks of paid sick leave and expanded family and medical leave paid at 2/3 for qualifying reason #5 below up to $200 daily and $12,000 total.

To request emergency paid sick leave as provided under FFCRA complete the request form and submit to your supervisor either prior to leave or within one day of leave commencing. Verbal notice will be accepted until a form can be provided.

Documentation supporting the need for leave must be included with this request.

Employee Name:_____ Position_____

Requested Leave Start Date:_____ End Date:_____

Qualifying Reasons for Leave Related to COVID-19

I am requesting this emergency paid sick leave due to my inability to work (or telework) because (check the appropriate reason below):

- ☐ 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 symptoms of COVID-19 and seeking a medical diagnosis.
- ☐ 4. I am caring for an individual who is subject to either #1 or self-quarantine as described in #2 above.
- ☐ 5. I am caring for my child whose primary or secondary school or place of care has been closed, or childcare provider is unavailable due to COVID-19 related reasons; and,
- ☐ 6. I am experiencing another substantially similar condition specified by the U.S. Department of Health and Human Services.

I have attached documentation supporting my need for leave.

Certification and Signature

Employee Signature: _____ Date _____

Supervisor Signature: _____ Date _____

Superintendent Signature: _____ Date _____