FAMILIES FIRST CORONAVIRUS RESPONSE ACT
COVID-19 LEAVE OF ABSENCE REQUEST FORM

Employee Name: _____

Department: _____

Supervisor: _____

TYPE OF LEAVE REQUESTED (please check all that apply):

☐ **SICK LEAVE - SELF**

- Subject to a federal, state or local quarantine or isolation order related to COVID-19 or
- Advised by a healthcare provider to self-quarantine due to concerns related to COVID-19 or
- Experiencing symptoms of COVID-19 and seeking a medical diagnosis
- Experiencing any other substantially-similar condition specified by the U.S. Department of Health and Human Services.

Anticipated Dates of Duration: _____

☐ **SICK LEAVE – FAMILY**

- Care for a family member who is subject to a government order to quarantine or isolate or
- Care for a family member who has been advised by a healthcare provider to self-quarantine.

Anticipated dates of Duration:_____

☐ **FAMILY LEAVE – CHILD CARE**

- is caring for his or her child whose school or place of care is closed (or paid child care provider is unavailable) due to COVID-19 reasons

Anticipated dates of Duration:_____

GROUP HEALTH INSURANCE PARTICIPATION:

☐ I understand that during this leave period, my health insurance coverage will continue under the same terms and conditions as prior to the leave, including continuing responsibility for any applicable employee premiums.

☐ I am not a participant of the group health insurance plan.

_____ _____

Employee Signature Date

Employees approved for leave under the FFCRA must log their time into ADP using the codes indicated.

- Code **COVID 19 Self** for Sick Leave – Self above
- Code **COVID 19 Family** for Sick Leave – Family above
- Code **COVID-19 Child Care** for Family Leave – Child Care above