

**FAMILIES FIRST CORONAVIRUS LEAVE ACT (FFCRA)**

**LEAVE REQUEST FORM**

The FFCRA includes leave provisions for employees that meet the eligibility and qualifying reason requirements. Employees in need of these leaves must complete this form and submit to Human Resources, at [asassara@vashonsd.org](mailto:asassara@vashonsd.org). **In all cases please review your union information (if applicable) for any additional details.**

**Employee Name:** \_\_\_\_\_

**Phone Number:** \_\_\_\_\_

**Email:** \_\_\_\_\_

**Supervisor:** \_\_\_\_\_

**School/Location:** \_\_\_\_\_

Check all options you are requesting under **Emergency Paid Sick Leave (EPSL)** and/or **Emergency Family & Medical Leave Expansion Act (EFMLEA)**. Up to 80 hours EPSL for full-time staff (pro-rated for part-time staff); any combination of FMLA and EFMLEA may not exceed 12 weeks.

- CHILD CARE:** I am unable to work as I have a need to care for my child(ren) whose school or child care facility or provider is closed/unavailable due to COVID-19. I represent that no other person will be providing care for my child(ren) during the period for which I am receiving EPSL and/or EFMLEA.

I am requesting that my leave be (check one):  Continuous     Intermittent (only available for Child Care option)

If your need for leave is intermittent, please describe the requested schedule:  
(You may attach documentation regarding closure of child care.)

\_\_\_\_\_

**Available Leave Options (review your union information (if applicable) for any additional details):**

**Dates**

- |   |       |
|---|-------|
| <input type="checkbox"/> EPSL (up to first 2 weeks paid EPSL at 2/3 wages capped at \$200/day)              | _____ |
| <input type="checkbox"/> EFMLEA (weeks 1 & 2 – UNPAID)  | _____ |
| <input type="checkbox"/> EFMLEA (weeks 1 & 2 – substitute ESPL pay as elected above)                        | _____ |
| <input type="checkbox"/> EFMLEA (weeks 1 & 2 – substitute available annual and/or sick leave at 100% wages) | _____ |
| <input type="checkbox"/> EFMLEA (weeks 3 through 12; 2/3 wages capped at \$200/day and \$12,000 total)      | _____ |

Name(s) & age(s) of children: \_\_\_\_\_

Name/address/phone of child care: \_\_\_\_\_

- EMPLOYEE'S QUARANTINE, ISOLATION, OR SYMPTOMS:** I am unable to work due to any of the following related to COVID-19 (check one): (Intermittent leave not applicable.)

- 1) I am subject to a federal, state, or local quarantine or isolation order.
- 2) I have been advised by a healthcare provider to self-quarantine. *(Attach supporting documentation.)*
- 3) I am experiencing symptoms and seeking a medical diagnosis. *(Attach supporting documentation.)*

**Available Leave Options (review your union information (if applicable) for any additional details):**

**Dates**

EPSL (up to 2 weeks paid EPSL at 100% of wages capped at \$511/day) \_\_\_\_\_

FMLA for employee's own serious health condition – COMPETE STANDARD FMLA FORMS

List source of quarantine or isolation order; if health care provider, provide name/address/phone AND attach supporting documentation from your healthcare provider.)

\_\_\_\_\_  
\_\_\_\_\_

**CARE FOR AN INDIVIDUAL UNDER QUARANTINE OR ISOLATION:** I am unable to work as I am caring for an individual who is subject to a quarantine or isolation order. Intermittent leave not applicable. *(Attach supporting documentation.)*

**Available Leave Options (review your union information (if applicable) for any additional details):**

**Dates**

EPSL (up to 2 weeks paid EPSL at 2/3 wages capped at \$200/day) \_\_\_\_\_

EPSL (up to 2 weeks substitute available annual and/or sick leave at 100% wages) \_\_\_\_\_

FMLA for family member's serious health condition – COMPLETE STANDARD FMLA FORMS

List the name and relationship of the person you are caring for:

\_\_\_\_\_

**ACKNOWLEDGEMENT**

I understand that where leave is foreseeable, I am responsible for providing notice to my supervisor and human resources as soon as it is practicable.

I further understand that providing false or misleading information is a violation of district policy 5281.

Employee Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**For HR Use:**

Leave Request is:     Approved                       Approved with changes                       Not approved

HR Signature: \_\_\_\_\_

Date: \_\_\_\_\_