FISD Leave Request Form (FFCRA) Emergency Paid Sick Leave and Expanded Family & Medical Leave

Employee completes this form then submits to Stacy Rush, Director of Human Resources stacyr@fisd.org Attach documents from your health care provider.

Name	**Employee ID**
Department/campus	**Position**
Email	**Phone number**
Date	**Duration of leave** *(specify dates requested)*

Leave benefits under the Families First Coronavirus Response Act (FFCRA) apply for the limited time period of April 1, 2020, to December 31, 2020. The amount of paid leave an employee may receive will vary depending on the reason leave is taken. Detailed information is available in the Employee Rights notice that can be found .

https://www.fisd.org/cms/lib3/TX50000116/Centricity/Domain/871/FFCRA_Poster_WH1422_Non-Federal.pdf

An employee requesting emergency paid sick leave and expanded family and medical leave must complete this form and return it to Stacy Rush as soon as the need for leave is identified. Documentation supporting the need for leave should be included when the request is submitted.

Emergency Paid Sick Leave (EPSL) is limited to 80 hours of paid leave at the following rates:

- Self: regular rate of pay up to $511 per day
- For care of an individual or a son or daughter: two-thirds the regular rate of pay up to $200 per day

Expanded Family and Medical Leave (EFML) provides up to 12 weeks of leave to care for a son or daughter when school is closed or child care is unavailable due to COVID-19. The first two weeks are unpaid, although the empoyee may access EPSL or other paid leave during this time. The remaining 10 weeks is two-thirds the regular rate of pay up to $200 per day.

I request leave for the following reason(s):

Self

___ I'm subject to a federal, state, or local quarantine or isolation order related to COVID-19.

Name of entity requiring quarantine or isolation: ____

___ I've been advised to self-quarantine by a health care provider.

Name of health care provider requiring self-quarantine: ____________________________

___ I'm experiencing symptoms of COVID-19 and am seeking a medical diagnosis.

Name of health care provider: ____

____ I tested positive for COVID-19 and I am unable to telework due to my job description or current health status

Name of health care provider:____

___ I'm expericing any other substantially-similar conditions specified by the U.S. Department of Health and Human Services.

Care for other individual or child

___ I'm unable to work in order to care for a minor son or daughter because their school is closed or child care is not available due to COVID-19.

Name of school or child care facility:____

Are you the only adult caring for the child(ren): _____yes _____no

Name and age of child(ren): ____

If the son or daughter is over the age of 14 describe special circumstance requiring the care:

____

___ I'm unable to work in order to care for an individual subject or advised to quarantine or isolate.

Name of individual: __________________________ Relationship: ________________________

Name of health care provider: ____

Designation *(completed by HR Department and a copy provided to the employee)***:**

_____The employee qualifies for EPSL.

_____The employee does not qualify for EPSL.

_____The employee qualifies for _____ weeks of EFML.

_____The employee does not qualify for EFML.

For office use only:

Date of Employment ______________________

Medical certification provided _____Yes _____ No

Approved by:____
Name and title

Date:_________________