| Information Required to Approve a Leave under the EFMLEA or the EPSLA Employee Name:Employee No.: | | |
|--|--|--|
| Company Name: Leave Request No.: | | |
| Instructions Please include your Name, Company Name, Employee Number, and leave request number above. You can find your leave request number in the top left corner of the letters we sent you related to this request. | | |
| Step 1: Please provide the required information about your employment. Step 2: Please select the applicable reason for your need for leave. Step 3: Please provide the dates for which you need leave. Intermittent leave is available in limited situations | | |
| and employer approval is needed; if you are requesting intermittent leave please provide frequency and dates of leave. | | |
| Step 4: Indicate the specific authority or entity that authorized or is responsible for your need for leave Please return this form by the due date listed on your request letter via fax or email. | | |
| Step 1: Employment Information Is the company for which you work currently closed for business or is your job subject to a work stoppage (e.g., furloughed your job)? Yes or No | | |
| If Yes, when will your company reopen or your job/work be reinstated: (MM/DD/YY) Does your employer provide you with the ability to telework? Yes or No If Yes, but you cannot telework (for all or part of your workday), please explain in step 1 the reason for your inability to telework and in step 2 the amount of time you are requesting. | | |
| Do you work for another employer (or have you worked for another employer since April 1, 2020)? Yes or No If Yes, have you collected Emergency Paid Sick Leave (EPSLA) from that employer? Yes or No | | |
| Step 2: Reason for leave I am requesting leave due to a COVID-19 qualifying reason for leave: (check applicable reason and sub-reasons, if applicable) | | |
| ☐ I am subject to a Federal, State, or local quarantine or isolation order related to COVID-19 | | |
| ☐ I have been advised by a health care provider to self-quarantine due to concerns related to COVID-19 ☐ I have COVID-19 | | |
| I may have COVID-19 due to known exposure or symptomsI am particularly vulnerable to COVID-19 | | |
| $\ \square$ I have been is experiencing symptoms of COVID-19 and I 'm seeking a medical diagnosis | | |
| □ I am caring for an individual who is subject who is subject to a quarantine/isolation order, or has been advised to self-quarantine by a health care provider for one of the following: □ The individual has COVID-19 | | |
| The individual may have COVID-19 due to known exposure or symptoms The individual is particularly vulnerable to COVID-19 | | |
| Name: Relationship: Please provide an explanation as to your inability to work or telework: | | |
| | | |
| | | |

| provider is unavailable, due to COVID-19 precautions. (Please mark (A) I am providing care to a child (or children) who is fourt (B) I am only providing care to a child (or children) who is 1 If you checked (B), please provide a statement regarding your inable (or children) 15 or older during daylight hours, please indicate any provide care. If your child (children) is 18 years old or older, also expected of self-care because of his/her disability and why you are needed to the control of the co | een years or younger 15 years old or older bility to work or telework to care for your child special circumstances regarding the need to xplain whether the child (children) is incapable |
|--|---|
| If you checked (B), please provide a statement regarding your inab (or children) 15 or older during daylight hours, please indicate any provide care. If your child (children) is 18 years old or older, also e | oility to work or telework to care for your child special circumstances regarding the need to xplain whether the child (children) is incapable |
| (or children) 15 or older during daylight hours, please indicate any provide care. If your child (children) is 18 years old or older, also e | special circumstances regarding the need to xplain whether the child (children) is incapable |
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| | |
| Step 3: Frequency of leave: I need the following frequency and duration of leave: Continuous – I am requesting to be off continuously for the following anticomes. | cipated dates: |
| Start date: (MM/DD/YY) End date: (MM/DD/YY) | лм/dd/yy) |
| Intermittent – I am able to work, but will require occasional absences for the following are requirements for taking Intermittent leave: There must be a clear and mutual understanding between you and Expanded Family and Medical Leave intermittently. While we are asking for an estimate below, the increments of intervou and your employer. For any leave request other than those related to school closures, if your employer's approval, if you are teleworking. | I your employer to take Paid Sick Leave or rmittent time must be mutually approved by |
| Start date:(MM/DD/YY) End date:(N | IM/DD/YY) |
| Please provide your best estimate of the frequency and duration. This esti review: | mate will be provided to your employer to |
| days per week OR days per month, lasting up to h | ours OR days per absences |

STEP 4: SUPPORTING INFORMATION

You are required to provide the following information appropriate to the reason for your leave.

This is subject to forthcoming rules from the Internal Revenue Service (IRS). If the IRS changes the requirements and additional documentation is needed, we will let you know.

| | If you've been advised by a health-care provider to self-quarantine or you're caring for an individual who was advised to quarantine provide <i>the name of the health care provider who advised him or her to self-quarantine for COVID-19 related reasons:</i> | | | |
|--------|--|---|--|--|
| | | experiencing symptoms of COVID-19 and is seeking a medical diagnosis provide – A complete and sufficient FMLA medical certification. You can find a copy of an acceptable certification in your initial request packet. | | |
| Emplo | place of the follo 1. 1 2. 1 3. 4. 4 | unable to work (or telework) due to a need to care for a the son or daughter if the child's school or child care has been closed or is unavailable due to a COVID-19-related public health emergency, provide wing: the name of the child(ren) being care for; the name of the school, place of care, or child care provider that closed or became unavailable due to COVID-19 reasons If the child you are caring for is over the age of 18 you will need to complete the attached Disability Certification for individuals 18 and up. A statement representing that no other suitable person is available to care for the child during the period of requested leave. | | |
| Employ | vee Signat | ture: Date: | | |

Confidential fax: 877-309-0218 or
Email: FMLAcenter@FMLAsource.com
In the subject line of your email, please write "Families First Documentation

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic information," as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

EMPLOYEE RIGHTS

PAID SICK LEAVE AND EXPANDED FAMILY AND MEDICAL LEAVE UNDER THE FAMILIES FIRST CORONAVIRUS RESPONSE ACT

The Families First Coronavirus Response Act (FFCRA or Act) 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

Generally, employers covered under the Act must provide employees:

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

- 100% for qualifying reasons #1-3 below, up to \$511 daily and \$5,110 total;
- 3/4 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 % for qualifying reason #5 below for up to \$200 daily and \$12,000 total.

A part-time employee is eligible for leave for the number of hours that the employee is normally scheduled to work over that period.

▶ ELIGIBLE EMPLOYEES

In general, employees of private sector employers with fewer than 500 employees, and certain public sector employers, are eligible for up to two weeks of fully or partially paid sick leave for COVID-19 related reasons (see below). *Employees who have been employed for at least 30 days* prior to their leave request may be eligible for up to an additional 10 weeks of partially paid expanded family and medical leave for reason #5 below.

QUALIFYING REASONS FOR LEAVE RELATED TO COVID-19

An employee is entitled to take leave related to COVID-19 if the employee is unable to work, including unable to **telework**, because the employee:

- is subject to a Federal, State, or local quarantine or isolation order related to COVID-19;
- has been advised by a health care provider to self-quarantine related to COVID-19;
- is experiencing COVID-19 symptoms and is seeking a medical diagnosis;
- is caring for an individual subject to an order described in (1) or self-quarantine as described in (2);
- is caring for his or her child whose school or place of care is closed (or child care provider is unavailable) due to COVID-19 related reasons; or
- is experiencing any other substantially-similar condition specified by the U.S. Department of Health and Human Services.

ENFORCEMENT

The U.S. Department of Labor's Wage and Hour Division (WHD) has the authority to investigate and enforce compliance with the FFCRA. Employers may not discharge, discipline, or otherwise discriminate against any employee who lawfully takes paid sick leave or expanded family and medical leave under the FFCRA, files a complaint, or institutes a proceeding under or related to this Act. Employers in violation of the provisions of the FFCRA will be subject to penalties and enforcement by WHD.



For additional information or to file a complaint:

1-866-487-9243

TTY: 1-877-889-5627 dol.gov/agencies/whd

