**Leave Request Form**

Date of request: \_\_\_\_\_\_\_\_\_\_\_\_\_\_  Employee name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Department: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Job title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Paid Sick (COVID-19 Paid Sick Leave, 80 hours maximum)** Leave provides 100% of pay for 1,2,3 up to $511 a day maximum, cap $5110. 2/3 pay for 4,5,6, up to $200 a day maximum, cap $2000.

Start date: \_\_\_\_\_\_\_\_ End date: \_\_\_\_\_\_\_\_ Total hours: \_\_\_\_\_\_\_\_

Reason: *(Include providers note if available, employee written statement of reason for the need for leave, with this request form. Additional documentation may be requested to substantiate leave request)*

[ ] 1. Employee subject to a Federal, State, or local quarantine or isolation order related to coronavirus

[ ] 2. Employee has been advised by health care provider to self-quarantine due to coronavirus

[ ] 3. Employee is experiencing symptoms of coronavirus

[ ] 4. Employee is caring for an individual who is subject to an order described in (1) or has been advised as described in (2)

[ ] 5. Employee is care for their child because the school is closed, or childcare provider is unavailable, due to coronavirus. (Provide proof of closure for this reason)

[ ] 6. Employee is experiencing a similar condition specified by Secretary of HHS.

**Paid Family Medical Leave (COVID-19 FMLA Leave):** This leave is up to 12-weeks paid with the first 10-days unpaid due to school closures related to COVID-19. Leave provides 66.7% of regular pay, up to $200 a day, capped at $10,000 maximum. (Provide supporting documentation of the school closure, a written statement of reason, and return with this form.

Start date: \_\_\_\_\_\_\_\_ Anticipated end date: \_\_\_\_\_\_\_\_ Total hours: \_\_\_\_\_\_\_\_

**Statement of Reason for request:**

This form should not be used to request unpaid leave under the Family and Medical Leave Act (FMLA) or to request leave as an accommodation under the Americans with Disabilities Act (ADA). Please contact Human Resources for those specific requests.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_       \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Employee signature                                                       Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_       \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Supervisor signature                                                    Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_       \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Human resources representative signature                   Date

***File original in the employee’s leave records and provide a copy to the employee,***