hradvantageweb.net | 877-894-0202
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Employee Leave Request Form
(COVID-19 Related)

Under the Families First Coronavirus Response Act effective April 1, 2020 – December 31, 2020 you may be eligible to request emergency paid sick leave or emergency Family & Medical Leave. Please complete the following request form and submit to your manager or Human Resources as soon as possible before your leave commences, to assist us in making an assessment for eligibility.

Verbal notice may be accepted until a form can be provided. Documentation supporting the need for leave must be included with this request.

Employee Name (print/type):_____ Department:_____
Manager Name:_____ **Requested Leave Start Date:_____ End Date:_____**
The amount of emergency paid sick leave being requested in hours:_____.

If requesting intermittent leave for reason #5 below, leave is requested for the following days/hours:

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

I am requesting to take emergency paid sick leave or emergency Family & Medical Leave due to my inability to work (or telework) because of the following (Please check the applicable reason(s) below).

Emergency Paid Sick Leave Qualifications:

	1	I am subject to a federal, state, or local quarantine or isolation order related to COVID-19.*
	2	I have been advised by a health care provider to self-quarantine related to COVID-19.*
	3	I am experiencing COVID-19 symptoms and am seeking a medical diagnosis.*
	4	I am caring for an individual subject to an order described in (1) or (2).**

Emergency Paid Sick Leave and/or Emergency FMLA Qualifications:

	5	I am caring for my child whose school or place of care is closed (or child care provider is unavailable) due to COVID-19 related reasons.** ☐ I attest that no other suitable caregiver is available to care for my child(ren) during the requested period of leave.
	6	I am experiencing another substantially-similar condition specified by the U.S. Department of Health and Human Services.**

*For qualifications 1-3, Emergency Paid Sick Leave is paid at employee's average daily wages up to $511 per day for a maximum of ten days.
**For qualifications 4-6, Emergency Paid Sick Leave is paid at 2/3 (two-thirds) of employee's average daily wages up to $200 per day for a maximum of ten days.
Please seek guidance from HR regarding how much time is available. You may qualify for up to ten additional weeks of paid Family & Medical Leave for reason #5.

I attest that the information is accurate and complete. I have attached supporting documentation. I understand falsification of any information given may lead to disciplinary action up to and including termination.

_____ _____
Employee Signature **Date**

_____ _____
Company Representative Authorization **Date**

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Employee Statements / Supporting Documentation

I (print: employee name):_____, am providing the following information in support of my request for emergency paid sick leave or emergency Family & Medical Leave (complete all that apply):

Leave due to a government-issued quarantine or isolation order **(for reason #1, 3 or 4)**

Name of the issuing government agency for the quarantine or isolation order: _____
Effective dates of the order: _____

Leave due to a health care provider's advice to self-quarantine (for reason #2, 3 or 4)

Name of the health care provider advising me or the individual I am caring for to self-quarantine: _____
_____

*Written documentation is available and attached: ❑Yes ❑No

Name and relation of the individual who I am needed to care for:

Name:_____ Relation:_____

Leave due to a school or place of child care closed due to COVID-19 (for reason #5)
Name of school, place of care, or child caregiver that is closed or unavailable due to concerns related to COVID-19:
_____

Name and age of child or children I am needed to care for:
Name: _____Age: _____
Name: _____Age: _____
Name: _____Age: _____
Relationship to above children:_____

No other suitable person is available to care for my child for the requested leave period due to:
_____
_____

Leave due to a substantially similar condition specified by the Secretary of Health and Human Services. Provide details regarding the need for this leave:_____
_____

I certify I am unable to work (or telework) due to the reason listed above.

_____ _____
Employee Signature **Date**

_____ _____
Company Representative Authorization **Date**