



Families First Coronavirus Response Act (HR 6201) Request Form

PLEASE TYPE OR PRINT

| | | | | |
|----------------------------|--------------------------|---|--------------|---|
| Name: Last | First | Middle | Phone Number | Employee Number <small>(DO use only)</small> |
| Street Address/PO Box | | City | State | Zip Code |
| Date Leave Requested From: | Date Leave Requested To: | Requesting Continuous or Intermittent Time: | | Department / Site |
| | | <input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent | | |

INSTRUCTIONS:

Select a reason below for your Emergency Paid Sick Leave request and/or the Expanded Family Medical Leave Act request and attach the required document. Both sections (4) and (5) require a written statement of reason:

I am requesting Emergency Paid Sick Leave (EPSL) and/or the Extended FMLA under the Families First Coronavirus Response Act (HR 6201) for the following reason(s):

- (1) I am *subject to quarantine or isolation order related to COVID-19 by federal, state, or local government*
 - I have attached a copy of the documentation from the government entity or health care provider that issued the order **or**;
 - I completed section (1) of page two

- (2) I have *been advised to self-quarantine related to COVID-19 by a healthcare provider*
 - I have attached a copy of the documentation from the health care provider who gave the advice **or**;
 - I completed section (2) of page two.

- (3) I am experiencing COVID-19 symptoms and seeking medical diagnosis
 - I completed section (3) of page two

- (4) I am caring for an individual who is subject to (1) or (2) above: (must check two boxes for completion)
 - I have attached a copy of the documentation from the government entity or health care provider that issued the order **or**;
 - I completed section (1) of page two;
 - And**, I have included a statement on section (4a) of page two that no other suitable person is available to care for the individual.

- (5) I am caring for a dependent child (under 18) whose school or place of care is closed or whose caregiver is unavailable due to COVID-19 precautions: (must check two boxes for completion)
 - I have attached documentation from my child’s school, placement of care facility, or caregiver **or**;
 - I completed section (5) of page two.
 - And**, I have included a statement on section (4a) of page two that no other suitable person is available to care for my child.

- (6) I am experiencing a “substantially similar condition” as specified by federal agencies
 - I completed section (6) of page two

**Families First Coronavirus Response
Act (HR 6201) Request Form**

| | | |
|-------------------------------|---------------------------------|--------------------------|
| Employee's Name: _____ | Worksite Location: _____ | Supervisor: _____ |
|-------------------------------|---------------------------------|--------------------------|

This form is to be filled out if from page 1 you checked boxes (1), (2), or (3) and do not have documentation to attach, or you checked off boxes (4) or (5).

(1) *Government entity and/or health care provider that issued the order:*

Name: _____
Address: _____
Telephone: _____

(2) *Government entity and/or health care provider that issued the order:*

Name: _____
Address: _____
Telephone: _____

(3) *Government entity and/or health care provider that you will be seeking medical advice from:*

Name: _____
Address: _____
Telephone: _____

(4) *Individual you are caring for and the relationship to employee of the Junction Elementary School District, and the government entity and/or health care provider that issued the order:*

Name of Individual: _____
Relationship: _____
Name of government entity or health care provider: _____
Address: _____
Telephone: _____

4a) Statement of reason: _____

(5) *Dependent child and school, place of care, or caregiver:*

Name of child: _____ Age of child: _____
School/place of care/caregiver: _____
Address: _____
Telephone: _____

5a) Statement of reason: _____

(6) *Government entity and/or health care provider that you will be seeking medical advice from:*

Name: _____
Address: _____
Telephone: _____

My signature below assures that I meet the criteria listed above and qualify for EPSL and/or the EFMLA as I am unable to work, either at an assigned work site or in a remote assignment offered by the Junction Elementary School District.

Signature

Date