# East Dubuque CUSD #119
# Family First Coronavirus Response Act (FFCRA)
# Leave Request Form

FFCRA provides up to two weeks (80 hours, or a part-time employee's two-week equivalent) of paid emergency sick leave to eligible employees for absences due to COVID-19. There are specific qualifying reasons related to COVID-19 under this Act and medical documentation must follow each request. To request an FFCRA Leave, complete this form and return it to the Superintendent or Principal.

Employee Name: ______________________________

Position: ______________________________

Dates of Requested Leave: ______________________________

**_Reason for Requested Leave (Select one):_**

_____ ***Federal, State, or local quarantine or isolation order related to COVID-19***
(Attach documentation from the local health department.)

Duration of quarantine or isolation order: ______________________________

Will you be working remotely during the quarantine period: _____ YES _____ NO

_____ ***Advised by a health care provider to self-quarantine due to concerns related to COVID-19***
(Attach documentation from the local health department.)

Name of health care provider advising self-quarantine: ______________________________

Date self-quarantine advised: ______________________________

Duration of advised self-quarantine: ______________________________

Will you be working remotely while waiting for medical diagnosis or clearance to return to work?

_____ YES _____ NO

_____ ***Experiencing symptoms of COVID-19 and seeking a medical diagnosis***

Symptoms: ______________________________

Date symptoms began: ______________________________

Date of anticipated diagnosis: ______________________________

Will you be working remotely while waiting for medical diagnosis or clearance to return to work?

_____ YES _____ NO

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_____ ***Caring for an individual who is subject to a quarantine or isolation order or has been advised to self-quarantine***

Name of individual quarantined or self-quarantined: ______________________________

Relation to you: ______________________________

Basis for self-quarantine (if applicable):

_____ Has COVID-19 _____ May have COVID-19 due to know exposure or symptoms
_____ Particularly vulnerable to COVID-19

Nature of Care provided: ______________________________

Name of governmental entity/health care provider ordering quarantine/isolation/self-quarantine:

______________________________

Date self-quarantine advised: ______________________________

Duration of advised self-quarantine: ______________________________

Will you be working remotely?

_____ YES _____ NO

***Be sure to attach any necessary documentation from health care providers, health departments, or other entities to verify the information provided for this request. Sign the document and return it to the Superintendent or Principal as soon as possible. If you have any questions, contact the superintendent or principal.***

______________________________ ______________________________

**Employee Signature** **Date**

______________________________ ______________________________

***Administrative Approval*** ***Date***