FAMILIES FIRST CORONAVIRUS RESPONSE ACT (FCCRA)
REQUEST FOR LEAVE

Effective April 1, 2020, and ending on December 31, 2020, Ottawa County employees will be entitled to expanded leave under and in accordance with the Families First Coronavirus Response Act (FCCRA). As a result, any employee requesting leave under this Act shall complete this form as described in the County's ***Families First Coronavirus Response Act*** policy.

Employee Name:_____ **Date:**_____

LEAVE(S) REQUESTED (please check):

FAMILY & MEDICAL LEAVE *("Public Health Emergency Leave")*

Beginning Date:_____

Ending Date*:_____

** Has the employee exhausted any or all of their annual FMLA entitlement? If so, this impacts the amount of time they are entitled to under the Expansion provision. Total Leave cannot exceed 12 weeks.*

FIRST 10 DAYS: *Public Health Emergency Leave* is **unpaid for the first ten (10) days** of the Leave. Employees may elect to supplement this unpaid time with otherwise available paid leave.

Is the employee requesting to substitute available accrued leave during this time?

Yes _____ No _____

If yes, specify the type of leave requested for substitution:

_____ Emergency Paid Sick _____ Vacation

_____ Comp Time _____ Sick Leave*

Eligibility must meet County's policy for use of traditional Sick Leave

NEXT 10 WEEKS: After the first 10 days, the Leave is **paid at two thirds (2/3)** the employee's regular earnings. Employees may elect to supplement the missing third (1/3) with otherwise available paid leave.

Is the employee requesting to supplement the partial paid leave with other available accrued leave? _____ Yes _____ No

If yes, specify the type of leave requested:

_____ Vacation _____ Comp Time

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EMERGENCY SICK LEAVE (2 weeks)

Beginning Date/Time of Leave:_____

Ending Date/Time of Leave:_____

Reason for Leave (please check):

☐ 1. Employee is subject to a Federal, State, or Local quarantine or isolation order related to COVID-19 – *Must provide evidence of the Order*

☐ 2. Employee has been advised by a health care provider to self-quarantine due to concerns related to COVID-19 – *Must provide evidence from provider*

☐ 3. Employee is experiencing symptoms of COVID-19 and seeking a medical diagnosis – *Must provide documentation from treating health care provider*

☐ 4. Employee is caring for an individual who is subject to an order as described in (1) or has been advised as described in (2) – *Must provide evidence of the Order (for #1) or provider's recommendation (for #2)*

☐ 5. Employee is caring for a son or daughter whose school or place of care has been closed, or the child care provider of such son or daughter is unavailable, due to COVID-19 precautions

☐ 6. Employee is experiencing any other substantially similar condition specified by the Secretary of Health and Human Services in consultation with the Secretary of the Treasury and the Secretary of Labor.

Items 4, 5 and 6 above are paid at **two thirds (2/3)** the employee's regular earnings. Employees may elect to supplement the unpaid third (1/3) with available paid leave.

Is the employee requesting to supplement the partial paid *Emergency Sick Leave* with other available accrued leave? _____ Yes _____ No

If yes, specify the type of leave requested:

_____ Vacation _____ Comp Time _____ Sick Leave*

Eligibility must meet County's policy for use of traditional Sick Leave

"I certify all statements herein to be complete and true. Falsification is cause for discipline up to and including termination of employment."

_____ _____
Signature of Employee Date

_____ _____
Signature of Department Head/Supervisor Date

_____ _____
Signature of Appointing Authority Date