New Frontiers Public Schools

FFCRA Leave Request Form

Emergency Paid Sick Leave (EPSL) & Expanded Family and Medical Leave (EFML)

Name	**Date Submitted**
Department/campus	**Position**
Email	**Phone number**
Duration of leave *(specify all dates requested)*	

Leave benefits under the Families First Coronavirus Response Act (FFCRA) applied for the limited time period of April 1, 2020, to December 31, 2020. New Frontiers Public Schools has approved the extension of FFRCA leave benefits through June 3, 2021. The amount of paid leave an employee may receive will vary depending on the reason leave is taken. Detailed information is available in the FFCRA Employee Rights Notice - WH1422.

An employee requesting emergency paid sick leave and expanded family and medical leave must complete this form and return it to Human Resources as soon as the need for leave is identified. Documentation supporting the need for leave should be included when the request is submitted.

Emergency Paid Sick Leave (EPSL) is limited to 80 hours of paid leave at the following rates:

- Self: regular rate of pay up to $511 per day
- For care of an individual or a son or daughter: two-thirds (2/3) the regular rate of pay up to $200 per day

Expanded Family and Medical Leave (EFML) provides up to 12 weeks of leave to care for a son or daughter when school is closed or child care is unavailable due to COVID-19. The first two weeks are unpaid, although the empoyee may access EPSL or other paid leave during this time. The remaining 10 weeks is two-thirds the regular rate of pay up to $200 per day.

I request leave for the following reason(s):

Self

☐ I'm subject to a federal, state, or local quarantine or isolation order related to COVID-19.

Name of entity requiring quarantine or isolation: _____

☐ I've been advised to self-quarantine by a health care provider.

Name of health care provider requiring self-quarantine:_____

☐ I'm experiencing symptoms of COVID-19 and am seeking a medical diagnosis.

Name of health care provider:_____

☐ I'm experiencing any other substantially-similar conditions specified by the U.S. Department of Health and Human Services.

Care for other individual or child

☐ I'm unable to work in order to care for a minor son or daughter because their school is closed or child care is not available due to COVID-19.

Name of school or child care facility: _____

Are you the only adult caring for the child(ren): ☐ yes ☐ no

Name and age of child(ren): _____

☐ If the son or daughter is over the age of 14 describe special circumstance requiring the care:

_____

☐ I'm unable to work in order to care for an individual subject or advised to quarantine or isolate.

Name of individual: _____ Relationship: _____

Name of health care provider:_____

Intermittent Leave

I'm requesting intermittent leave according to the following schedule (*dates*): _____

_____

Accrued leave use

EPSL *(Emergency Paid Sick Leave)***:**

☐ I choose to use my accrued paid leave to supplement the pay covered by EPSL so I receive 100 percent of my regular rate of pay.

EFML *(Expanded Family and Medical Leave)***:**

☐ I understand I am able to use my accrued paid leave concurrently with EFML. When accrued leave is exhausted, I will receive 2/3 pay for any remaining EFML.

Leave Type & Dates to be covered by accrued pay: _____

_____

I hereby certify that I am unable to work or telework because of the qualified reason stated above. I certify that this statement is true and accurate and understand that my employer is relying on my representations and that false representations may result in disciplinary action.

Employee Signature: _____ **Date**: _____

Designation:

(completed by HR Department and a copy provided to the employee)

☐ The employee qualifies for EPSL.

☐ The employee does not qualify for EPSL.

☐ The employee qualifies for _____ weeks of EFML.

☐ The employee does not qualify for EFML.

For office use only:

Date of Employment _____

Medical certification provided ☐ Yes ☐ No

Approved by:_____

Name and title

Date:_____