



# COVID-19 EMPLOYEE REQUEST FOR FAMILIES FIRST CORONAVIRUS RESPONSE ACT LEAVE

Under the FFCRA, an employee may qualify for paid sick time if the employee is unable to work (**or unable to telework**) due to a need for leave. To request emergency paid sick leave as provided under the Families First Coronavirus Response Act and Leander ISD's Emergency Paid Sick Leave Policy, please complete the following request form and submit to the Leave Office at [LeaveRequest@leanderisd.org](mailto:LeaveRequest@leanderisd.org) as soon as possible before leave commences.

**Documentation supporting the need for leave must be included with this request, as described in the FMLA Leave Expansion and Emergency Paid Sick Leave Policy. Employees will not be paid until this form and required documentation has been submitted.**

## Employee Information

First Name, Middle Initial

Last Name

Employee's Position Title

Campus/Department

Please select the reason you are unable to work:

- ☐ **I am subject to a Federal, State, or local quarantine or isolation order related to COVID-19.**

*(A full-time employee is eligible for 80 hours of leave, and a part-time employee is eligible for the number of hours of leave that the employee works on average over a two-week period. Paid at the regular rate of pay, up to \$511 per day and \$5,110 in the aggregate.)*

**Name of the issuing government agency for the quarantine or isolation order:**

\_\_\_\_\_

**Effective dates of the order:** \_\_\_\_\_

- ☐ **I have been advised by a health care provider to self-quarantine related to COVID-19.**

*(A full-time employee is eligible for 80 hours of leave, and a part-time employee is eligible for the number of hours of leave that the employee works on average over a two-week period. Paid at the regular rate of pay, up to \$511 per day and \$5,110 in the aggregate.)*

**Medical certification requiring you to self-quarantine must be provided by your doctor and attached to this request.**

- ☐ **I am experiencing COVID-19 symptoms and am seeking a medical diagnosis.**

*(A full-time employee is eligible for 80 hours of leave, and a part-time employee is eligible for the number of hours of leave that the employee works on average over a two-week period. Paid at the regular rate of pay, up to \$511 per day and \$5,110 in the aggregate.)*

**Medical certification regarding your symptoms/diagnosis must be provided by your doctor and attached to this request.**



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- ☐ I am caring for an individual subject to a federal, state or local quarantine or isolation order.

*(A full-time employee is eligible for 80 hours of leave, and a part-time employee is eligible for the number of hours of leave that the employee works on average over a two-week period. Paid at 2/3 of the regular rate up to \$200 per day and \$2,000 in the aggregate over a two-week period.)*

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

\_\_\_\_\_

Effective dates of the order: \_\_\_\_\_

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

Name: \_\_\_\_\_ Relation: \_\_\_\_\_

- ☐ I am experiencing any other substantially-similar condition specified by the Secretary of Health and Human Services, in consultation with the Secretaries of Labor and Treasury.

*(A full-time employee is eligible for 80 hours of leave, and a part-time employee is eligible for the number of hours of leave that the employee works on average over a two-week period. Paid at 2/3 of the regular rate up to \$200 per day and \$2,000 in the aggregate over a two-week period.)*

Provide details regarding the need for this leave:

\_\_\_\_\_  
\_\_\_\_\_

- ☐ I am caring for a child whose school or place of care is closed (or child care provider is unavailable) for reasons related to COVID-19.

*(A full-time employee who has been employed by LISD for at least 30 days is eligible for up to 12 weeks (10 weeks of which are paid) at 40 hours a week, and a part-time employee is eligible for leave for the number of hours that the employee is normally scheduled to work over that period. Paid at 2/3 of the regular rate up to \$200 per day and \$12,000 in the aggregate over a 12-week period.)*

Name of school or place of care that has been closed:

\_\_\_\_\_

School or place of care contact number:

\_\_\_\_\_

Name and age of child or children I am needed to care for:

Name: \_\_\_\_\_ Child's DOB: \_\_\_\_\_

Name: \_\_\_\_\_ Child's DOB: \_\_\_\_\_

Name: \_\_\_\_\_ Child's DOB: \_\_\_\_\_

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

\_\_\_\_\_  
\_\_\_\_\_

The special circumstances requiring my need for leave to care for a child age 15-17 are:

\_\_\_\_\_  
\_\_\_\_\_



## COVID-19 EMPLOYEE REQUEST FOR FAMILIES FIRST CORONAVIRUS RESPONSE ACT LEAVE

Date on which you wish to begin leave: \_\_\_\_\_

Date of anticipated return to work: \_\_\_\_\_

**I attest that the above information is accurate and complete. I understand falsification of any information given may lead to disciplinary action.**

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Refer to the [FFCRA Employee Paid Leave Rights](#) for more information.