Employee Request for Leave under the Families First Coronavirus Act (FFCRA) (Expires December 31, 2020)

Complete the below request for leave pursuant to the Emergency Paid Sick Leave Act (EPSLA) and/or the Emergency Family and Medical Leave Expansion Act (FMLEA) under the Families First Coronavirus Response Act (FFCRA), and return to the Office of Human Resources at b.taylor@wi.k12.ny.us, or mail to 100 Sherman Avenue, West Islip, New York 11705, as soon as possible.

Name:	

Anticipated Start Date of Leave:		**Anticipated End Date of Leave:**	

Reason for Leave (check all applicable below)	I am unable to work for the following reasons:

☐	1. I am subject to a Federal, State, or local quarantine or isolation order.
☐	2. I have been advised by a health care provider to self-quarantine related to COVID-19.
☐	3. I am experiencing COVID-19 symptoms and seeking a medical diagnosis.
☐	4. I am caring for an individual subject to an order described in (1), or self-quarantine as described in (2).
☐	5. I am caring for a child under the age of 18 whose school or place of care is closed (or childcare provider is unavailable) for reasons related to COVID-19.

If you selected reasons 1 or 2 above, provide the name of the governmental entity ordering the quarantine or the name of the health care provider advising self-quarantine. Also attach a copy of the quarantine order or correspondence from the health care provider advising self-quarantine.

Name of government entity	
Name of healthcare provider	

If you selected reason 3 above, paid leave is available only for the time you are unable to work while you are taking affirmative steps to obtain a medical diagnosis. By signing this application form, you are certifying and representing that you will obtain a medical diagnosis as expeditiously as possible, and upon receipt of such diagnosis, you will promptly advise us of any need for continued leave, or your ability to return to work.

If you selected reason 4 above, provide the name of the person for whom you are providing care and their relationship to you, as well as the name of the governmental entity ordering the quarantine or the name of the health care provider advising self-quarantine. Also attach a copy of the quarantine order or correspondence from the health care provider advising self-quarantine.

Name of the person	
Relationship to you	

Name of government entity	
Name of healthcare provider	

If you selected reason 5 above, please provide the following information:

Name(s) and Age(s) of your child/children:	

Name of the School/Place of Care that closed:	

Attach documentation indicating that the school or place of care has closed. Examples of acceptable documentation include a notice that has been posted on a government, school, or day care website; a notice published in a newspaper; or an email or a letter from an official of the school, place of care, or child care provider.

By providing the information above and signing this application form, you are certifying and representing that no other person will be providing care for your child or children during the period for which you are receiving leave pursuant to reason 5 above and you will be unable to work in the period of requested leave.

Note that your entitlement to EFMLEA leave for reason 5 beyond two weeks will be reduced by any FMLA leave you have taken within the applicable 12-month look back period. Please indicate whether you have taken any FMLA leave within the past 12-month period, and if so, the amount of the FMLA leave taken:

Please indicate if you have taken FMLA:	□ Yes □ No
If yes, indicate the amount of time taken:	

I certify that, for each of the days that I request leave, I am unable to work because of one of the five (5) reasons listed above. I certify that the above information is accurate and complete:

Employee Signature:	

Date:	