Request for Families First Coronavirus Response Act (FFCRA) Leave

Name:_____ Personal Email Address: _____

Department: _____ Personal Phone: _____

Position: _____ Current Address: _____

_____

Start Date of Anticipated Leave: _____ Expected Date of Return to Work: _____

Name of Immediate Supervisor _____

_____ **CONTINUOUS LEAVE** – I am requesting continuous leave because I am unable to telework or work an alternate work schedule

_____ **INTERMITTENT LEAVE** – I am able to work intermittently, less than my regularly scheduled hours, by physically reporting, working remotely or working an alternative work schedule as indicated below:

_____ # of hours per week I plan to be on leave

_____ # of hours per week I plan to work remotely

_____ # of hours per week I plan to work an alternate work schedule. The schedule I plan to work is

_____

PLEASE NOTE: For reasons 1-4 and 6 below, you will not be allowed to physically report to work. In addition, you can only take intermittent leave for these reasons if you have been approved to telework.

COVID-19 Related Reason for Leave (check applicable box and provide requested information):

____ 1. I am subject to a Federal, State, or local quarantine or isolation order related to COVID-19
Name of governmental entity ordering quarantine _____

____ 2. I have been advised by a heath care provider to self-quarantine related to COVID-19
Name of health care provider ordering quarantine _____

____ 3. I am experiencing COVID-19 symptoms and am 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)
Name of individual cared for _____ _____
Relationship to employee _____
Name of governmental entity or health care provider ordering quarantine _____

____ 5. I am caring for my child whose school or place of care is closed (or child care provider is unavailable) due to COVID-19 related reasons.

Name of Child (or children)	Age	Name of School or Childcare Closed
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

_____ I affirm that no other person will be providing care for my child (or children) during the period for which I am receiving family medical leave.

_____ Check if applicable - I am unable to work or telework because I need to provide care for a child older than fourteen (14) during daylight hours. The special circumstances that require me to provide care for this child are

_____

____ 6. I am experiencing any other substantially-similar condition specified by the U.S. Department of Health and Human Services
Please provide details of your request:_____

_____

Additional information may be requested as needed to substantiate the leave. I understand that a failure to return to work at the end of my leave period may be treated as a resignation unless an extension has been agreed upon and approved in writing by the City of Fargo.

Signature:_____ Date:_____

Supervisor Section: **This section must be completed by a supervisor from your department**

_____ This employee <u>can</u> telework _____ This employee <u>cannot</u> telework

_____	_____	_____
Supervisor Name – Printed	Supervisor Signature	Date

HR Section:

Leave Request Processed by _____ EE D.O.H. _____ FMLA Used (prior 12 months) _____

Date Request Received _____ Date Designated (if FMLA) _____