

COVID-19 Related Leave of Absence Request Form

If you are applying for a leave of absence due to issues arising from COVID-19, complete this form in its entirety and return to _____ at _____ as soon as possible.

Name: _____

Title: _____ Department: _____

Manager or Supervisor: _____

Date(s) of Requested Leave of Absence: Start Date: _____;
End Date: _____

I am requesting Paid Sick Leave (Up to 80 hours) Yes or No

I am requesting up to an additional 10 weeks of Expanded Family Leave Yes or No
The amount of paid leave being requested is _____ hours.

[Optional: I request to take intermittent leave to care for a child because of COVID-19 reasons for following days & hours: Note that intermittent leave is only permitted for teleworking employee with employer's consent.]

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

Please indicate why you are requesting leave by answering the questions below.

Are you requesting leave because a state, federal or local Department of Health or other governmental entity mandated you to quarantine or to be under precautionary isolation (this includes shelter-in-place and stay-at-home orders)?

YES or NO

If yes, state the name of the Department of Health or governmental entity issuing the order _____

Have you tested positive for COVID-19?

YES or NO

Are you experiencing symptoms of COVID-19?

YES or NO

If yes, describe your symptoms _____

Are you requesting leave because your doctor or other health care provider advised you to self-quarantine due to concerns related to COVID-19?

YES or NO

If yes, state the name of your doctor or health care provider _____

A note from your doctor or other health care provider must be submitted with this form (or provide an explanation of why you cannot submit a note from your doctor or health care provider).

Are you requesting leave because you are experiencing symptoms of COVID-19 and are currently seeking a medical diagnosis?

YES or NO

Are you experiencing symptoms of COVID-19?

YES or NO

If yes, describe your symptoms _____

Did you contact your doctor or other health care provider to schedule an appointment in order to obtain a medical diagnosis?

YES or NO

If yes, when is or was your appointment? _____

Have you been tested for COVID-19?

YES or NO

If yes, when were you tested and what was the test result? _____

Provide documentation of the date of the test and test result, if available.

Are you requesting leave because you need to care for an individual who was ordered to quarantine or isolate or shelter-in-place or stay-at-home by the Department of Health or other governmental entity?

YES or NO

What is the name of the individual you are caring for? _____

What is your relationship to that individual? _____

State the name of the Department of Health
or governmental entity issuing the order _____

Are you requesting leave because you need to care for an individual who was advised to self-isolate or shelter-in-place or stay-at-home by his/her doctor or other health care provider due to concerns related to COVID-19?

YES or NO

What is the name of the individual you are caring for? _____

What is your relationship to that individual? _____

State the name of the doctor or health care
provider that advised the individual to self-isolate _____

A note from the individual's doctor or other health care provider must be submitted with this form (or provide an explanation of why you cannot submit a note from the doctor or health care provider).

Are you requesting leave because you need to care for your child (or children) because the child's school or day care center is closed or because your child care provider is unavailable as a result of COVID-19?

YES or NO

Will you be the only person providing care for the child (or children) during the period for which you are requesting leave?

YES or NO

How old is the child (or children)? _____

If the child (or children) is 14 years old or older, are there any special circumstances that require you to be home to provide care?

YES or NO

If yes, describe the special circumstances _____

Identify the school or day care center or child care provider for each child _____

Date(s) of closure for each school or day care center or child care provider _____

If requested, you may be required to furnish a note or other communication from each school or day care center or child care provider with the date(s) of closure.

If you are eligible for leave relating to COVID-19, but would only receive partial pay while on leave, do you want to use your accrued paid time off to supplement any pay you may otherwise be entitled to receive in order to continue receiving full pay during the leave of absence period?

YES or NO

By signing below, I certify that I have provided true and complete information in response to the questions asked above, and that I am not able to work (or telework) due to the reason(s) for which I have requested leave, and if requesting leave to care for a child (or children) because of school or childcare unavailability, I certify that no other suitable person is available to care for my child (or children) during the requested period of leave.

Employee Signature

Date