FFCRA LEAVE OF ABSENCE REQUEST

Name	Date
Job Title	**Client Company Where Assigned**

To request leave on the basis of the FFCRA (Families First Coronavirus Response Act), please complete the following request form and submit to your All StarZ Staffing representative as soon as practical.

TO BE COMPLETED BY EMPLOYEE:

A. I request a paid leave of absence under the Emergency Paid Sick Leave Act beginning _____ (insert date). I am unable to work or telework because:

☐ I am subject to a Federal, State, or local quarantine or isolation order related to COVID–19 (attach documentation).

☐ I have been advised by a health care provider to self-quarantine due to concerns related to COVID-19 (attach documentation).

☐ I am experiencing symptoms of COVID-19 and am seeking a medical diagnosis (attach documentation).

☐ I am caring for an individual who is subject to a Federal, State, or local quarantine or isolation order related to COVID–19 or who has been advised by a health care provider to self-quarantine due to concerns related to COVID-19 (attach documentation).

☐ I am caring for my minor son or daughter because my child's school or place of care has been closed, or the child care provider of my child is unavailable, due to COVID–19 precautions (attach documentation).

☐ I am experiencing any other substantially similar condition specified by the Secretary of Health and Human Services in consultation with the Secretary of the Treasury and the Secretary of Labor (attach documentation).

B. I request approval for a paid leave of absence under the Emergency Family and Medical Leave Expansion Act beginning _____ (insert date) because:

☐ I am unable to work or telework due to a need to care for my minor son or daughter because my child's school or place of care has been closed, or the child care provider of my child is unavailable, due to COVID–19 precautions (attach documentation).

LEAVES OTHER THAN THE ABOVE ARE NOT FFCRA ELIGIBLE

I understand that prior to any leave, I must make arrangements to continue insurance coverage if I am eligible. Further, I understand that I must contact HR and/or my supervisor before I can return to work.

Employee Signature _____ Date _____

❖ Completed form will be maintained in a confidential file, separate from your personnel file.

FFCRA LEAVE OF ABSENCE REQUEST

TO BE COMPLETED BY MANAGEMENT:

Notes

(job restoration, maximum length, insurance, benefit accrual, service, review date, etc.)

Approved by _____ Date _____

Disapproved by _____ Date _____