



Families First  
Coronavirus Response  
Act (FFCRA)

Leave Request Form

Employee Name: \_\_\_\_\_

Cell/Home # \_\_\_\_\_

Building/Department: \_\_\_\_\_

Principal/Supervisor: \_\_\_\_\_

***FFCRA Effective through December 31, 2020***

To be approved for leave under the Families First Coronavirus Response Act (FFCRA), employees must complete and submit this request form along with supporting documentation to Oak Grove R-VI School District's Human Resource Department.

This request form and supporting documentation shall be emailed to [spavlica@ogr6.org](mailto:spavlica@ogr6.org)

**Supporting Documentation for leave MUST include the following:**

- Copy of the Federal, State or local quarantine or isolation order related to COVID-19
- Documentation from a healthcare provider advising employee to self-quarantine due to COVID-19
- Documentation from a healthcare provider designating employee as a qualified caregiver due to COVID-19
- Written notice of closure from employee's child(ren)'s daycare provider or school due to COVID-19  
*(Need for such notice of closure or unavailability from the employee's child's school, place of care, or childcare provider, may be met by a notice that may have been posted on a government, school, or daycare website, newspaper publishing, or emailed to the employee from an employee or official of the school, place of daycare or childcare provider.)*

The FFCRA provides emergency paid sick time and expands family and medical (FML) through the Emergency Paid Sick Leave and the Emergency Family and Medical Leave Expansion Acts. Information about eligibility, pay caps, and leave allowances is available on the OGR6 website under Human Resources, Employee Benefits, Employee's Rights-FFCRA at [http://www.oakgrove.k12.mo.us/human\\_resources/employee\\_resources](http://www.oakgrove.k12.mo.us/human_resources/employee_resources)

**Please check the leave type that applies. Supporting documentation must be provided for each type selected:**

1. I am being subject to a Federal, State, or local quarantine or isolation order related to COVID-19;
2. I am being advised by a healthcare provider to self-quarantine due to COVID-19;
3. I am experiencing COVID-19 symptoms and am seeking a medical diagnosis;
4. I am caring for an individual who is subject to an order described in (1) or self-quarantine
5. I am caring for a son or daughter under 18 years of age whose school or place of care is closed (or childcare provider is unavailable) for reasons related to COVID-19; or
6. I am experiencing other substantially-similar condition specified by the Secretary of Health and Human Services, in consultation with the Secretaries of Labor and Treasury

**Please indicate the paid leave or personal time to be used (check all that apply):**

Two weeks (up to 80 hours) of **EMERGENCY PAID SICK LEAVE ACT (EPSLA)**

Starting date: \_\_\_\_\_ and Ending Date: \_\_\_\_\_

- Employee is unable to work due to:
  - I am being quarantined pursuant to Federal, State, or local government order or advice of a health care provider, or
  - I am experiencing COVID-19 symptoms and seeking a medical diagnosis.
- Paid at employee's regular rate of pay (maximum of \$511 per day or \$5,110 total)

Two weeks (up to 80 hours) of **EMERGENCY PAID SICK LEAVE ACT (EPSLA)**

Starting date: \_\_\_\_\_ and Ending Date: \_\_\_\_\_

- Employee is unable to work due to:
  - I have a bona fide need to care for an individual subject to quarantine pursuant to Federal, State, or local government order or advice of a health care provider;
  - I need to care for a child (under 18 years of age) whose school or childcare provider is closed or unavailable for reasons related to COVID-19; or,
  - I am experiencing a substantially similar condition as specified by the Secretary of Health and Human Services, in consultation with the Secretaries of the Treasury and Labor
- Paid at two-thirds the employee's regular rate of pay (maximum of \$200 per day or \$2,000 total)

Up to 10 weeks of **EMERGENCY FAMILY AND MEDICAL LEAVE EXPANSION ACT (EFMLEA)**

Starting date: \_\_\_\_\_ and Ending Date: \_\_\_\_\_

- Employee is unable to work due to:
  - I have a bona fide need to care for my CHILD (under 18 years of age) whose school or childcare provider is closed or unavailable for reasons related to COVID-19.
- Paid at two-thirds the employee's regular rate of pay (maximum of \$200 per day or \$10,000 total)

Up to 10 weeks of **LEAVE UTILIZING EMPLOYEE'S ACCRUED PERSONAL LEAVE**

Starting date: \_\_\_\_\_ and Ending Date: \_\_\_\_\_

- Employee is unable to work due to:
  - I have a bona fide need to care for an individual subject to quarantine (pursuant to Federal, State, or local government order or advice of a health care provider);
  - I am caring for my child (under 18 years of age) whose school or childcare provider is closed or unavailable for reasons related to COVID-19; or,
  - I am experiencing a substantially similar condition as specified by the Secretary of Health and Human Services, in consultation with the Secretaries of the Treasury and Labor.
- Paid at employee's regular rate of pay if personal time is available

**Any additional information may be provided below. Supporting documentation may be attached as a separate document(s).**

Please initial by each statement to denote you understand and agree to the following provisions:

I understand and agree to the following:

- I understand I must provide required supporting documentation for the leave I am requesting.
- I understand I am eligible for up to 12 weeks of FMLA and this leave may be taken intermittently.
- I understand, if applicable, depending on how much FMLA leave I have already taken, I may have already exhausted my FMLA leave for the period or may only be entitled to a portion of leave under this Act.
- I understand the first 10 days (two weeks) of FMLA are unpaid, but I may substitute and use emergency sick leave or my accrued personal leave during this period.
- I understand I can also use the paid sick leave under the Emergency Paid Sick Leave Act to cover these first 10 days. The remaining period of the 10 weeks is paid at 2/3 regular rate of pay but may be subject to federal limitations.
- I understand after 12 weeks or the amount of approved leave is exhausted I must notify my Principal of my intent to return to work.
- I understand I will continue to receive board paid health and dental benefits while on FMLA and I will be responsible for paying the additional employee/dependent monthly costs. Should I fail to pay the additional premium amount, the coverage will be changed to Employee Only level and optional coverages will be terminated.

I hereby certify that the above listed information is true and correct. Further, as an employee of the Oak Grove R-VI School District, I understand that falsification of information on this leave request form may lead to disciplinary action, up to and including discharge from employment.

Employee signature: \_\_\_\_\_

Date: \_\_\_\_\_