



FFCRA Sick Leave Form

Return completed form with documentation to Human Resources including Administrator's Signature

Eligibility Criteria (please check one): (I understand I can be reimbursed for up to a total of 80 hours of leave. This is not 80 hours per instance.)

1. _____ I am subject to a federal, state or local quarantine or isolation order related to COVID-19. **(documentation required) *I understand I can be reimbursed for leave at 100% of daily rate of pay. Maximum amount is \$511 per day up to \$5,110 in the aggregate.**

2. _____ I was advised by a health care provider to self-quarantine due to concerns related to COVID-19. **(documentation required) *I understand I can be reimbursed for leave at 100% of daily rate of pay. Maximum amount is \$511 per day up to \$5,110 in the aggregate.**

3. _____ I am experiencing symptoms of COVID-19 and seeking a medical diagnosis. **(documentation required) *I understand I can be reimbursed for leave at 100% of daily rate of pay. Maximum amount is \$511 per day up to \$5,110 in the aggregate.**

4. _____ I am caring for an individual subject to a federal, state or local quarantine or isolation order or advised by a health care provider to self-quarantine due to COVID-19 concerns. **(documentation required)*I understand I can be reimbursed for leave at 2/3 of daily rate of pay. Pay is capped at \$200 a day up to \$2,000 in the aggregate.**

5. _____ I am caring for a son or daughter, **under the age of 18**, of such employee if the school or place of care of the son or daughter has been closed, or the childcare provider of such son or daughter is unavailable, due to COVID-19 precautions. **(documentation required) *I understand I can be reimbursed for leave at 2/3 of daily rate of pay. Pay is capped at \$200 a day up to \$2,000 in the aggregate.**

6. _____ 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. **(documentation required) *I understand I can be reimbursed for leave at 2/3 of daily rate pay. Pay is capped at \$200 a day up to \$2,000 in the aggregate.**

Required Additional Criteria:

_____ I **do not** have the option to telework

I certify that the above information is accurate and that I have attached documentation, if required.

Print Name: _____ Employee ID: _____

Signature: _____ Date: _____

Administrator's Signature: _____ Date: _____

Eligible: _____ Not Eligible: _____
Leave Start Date: _____ Leave End Date: _____ Percentage Daily rate: _____
Human Resources: _____