

**Taunton Public Schools**  
**FAMILIES FIRST CORONAVIRUS RESPONSE ACT LEAVE**  
**REQUEST FORM**

***To request leave on the basis of the Families First Coronavirus Response Act (FFCRA) effective April 1, 2020 – December 31, 2020, please complete the following request form and submit to Human Resources as soon as possible.***

Employee Name (print clearly) \_\_\_\_\_ Email: \_\_\_\_\_

Position: \_\_\_\_\_ School: \_\_\_\_\_ Date: \_\_\_\_\_

Requested Leave Start Date: \_\_\_\_\_ Estimated End Date: \_\_\_\_\_

The reason for this FFCRA leave request is (select the most appropriate box):

1. I am seeking Emergency Paid Sick Leave as I am subject to a Federal, State or local quarantine or isolation order related to COVID-19. Employee eligible to receive up to two total weeks of paid sick leave up to \$511/day and \$5,110/aggregate.

*Name of government entity issuing the order:* \_\_\_\_\_

2. I am seeking Emergency Paid Sick Leave as I have been advised by a health care provider to self-quarantine related to COVID- 19. Employee eligible to receive up to two total weeks of paid sick leave \$511/day and \$5,110/aggregate.

*Name of advising health care provider:* \_\_\_\_\_

3. I am seeking Emergency Paid Sick Leave as I am experiencing COVID-19 symptoms and is seeking a medical diagnosis. Employee eligible to receive up to two total weeks of paid sick leave \$511/day and \$5,110/aggregate.

4. I am seeking Emergency Paid Sick Leave as I am caring for an individual subject to an order described in (1) or self-quarantine as described in (2). Employee eligible to receive up to two total weeks paid sick leave at 2/3 regular rate of pay up to \$200/day and \$2,000/aggregate.

*Name and relationship of person caring for:* \_\_\_\_\_

*Name of government entity issuing the order:* \_\_\_\_\_

OR

*Name of advising health care provider:* \_\_\_\_\_

5a. I am seeking Emergency Paid Sick Leave as I have a bona fide need to care for my child under the age of 18 whose school or place of care is closed for COVID-19 related reasons. Employee eligible to receive up to two weeks paid sick leave at 2/3 regular rate of pay up to \$200/day and \$2,000/aggregate.\*

5b. I am also seeking Expanded FMLA Leave as I have a bona fide need to care for my child under the age of 18 whose school or place of care is closed for COVID-19 related reasons. Employee eligible to receive the first two weeks as unpaid leave (to be used concurrent with Emergency Paid Leave in 5a, above, if elected), and up to 10 additional weeks of paid sick leave at 2/3 regular rate of pay up to a cap of \$200/day and \$10,000/aggregate<sup>1,2</sup>. \* Employee will be required to supplement the paid leave with all available personal and vacation time (sick leave is not eligible to be used for this type of request). If all available personal and vacation leave is exhausted, employee will receive 2/3 pay up to \$200/day and \$10,000/aggregate.

Name of child(ren): \_\_\_\_\_

Name of school(s) or place(s) of care that is unavailable: \_\_\_\_\_

**\* Notice of closure or unavailability from the school/child care provider must be attached.**

Check here to confirm notice is attached.

Is any other suitable person available to care for your child? If no, please explain why. (Please be sure to explore the child-care opportunities that have been gathered for TPS employees to explore prior to checking this box).

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I elect to use my accrued paid sick and other available leave to supplement pay under the Emergency Paid Sick Leave (Reasons 1-5a, above. \*\*\*\*This is not available for reason 5b\*\*\*\*).

Type of Leave to Use: \_\_\_\_\_

**All requests must be also signed by your supervisor before submitting to Human Resources. Failure to include the Supervisor signature may slow down the approval process.**

**I certify that the above information is truthful and understand that misrepresenting my need for leave may be just cause for discipline, up to and including termination.**

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Supervisor's Signature \_\_\_\_\_ Date: \_\_\_\_\_

**For HR use ONLY:** Date received: \_\_\_\_\_

FFCRA approval: \_\_\_\_\_

FFCRA denied: \_\_\_\_\_

<sup>1</sup> The total available leave will be reduced by any FMLA time used by you in the past 12 months.

<sup>2</sup> In order to be eligible you must have worked for TPS for at least 30 calendar days.