

LEAVE REQUEST FORM
Families First Coronavirus Response Act:
Employee Paid Leave

Employee Name (print clearly) _____ Emp ID# _____ Date _____

Requested Period of Leave of Absence:

Employee Status:

Reason for Leave: I am r_u -19 that has

self-quarantine related to COVID-19.
seeking a medical diagnosis.

ks of pay at two-thirds the regular rate.

ed by a health care provider to self-quarantine related
are provider to self-quarantine related to COVID-19.
care is closed (or childcare provider is unavailable) for
onal 10 weeks of paid expanded family & medical leave

ar condition specified by the Secretary of Health and
of Labor and Treasury.

other than those listed above and below herein. If so,
