CITY OF CRANSTON
DEPARTMENT OF PERSONNEL
869 PARK AVENUE
CRANSTON, RHODE ISLAND 02910

***

FAMILIES FIRST CORONA VIRUS RESPONSE ACT

LEAVE REQUEST FORM

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Please complete each page in full and return to the Department of Personnel. You must provide documentation as necessary to support your request.

If you have any questions contact:
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Director of Personnel
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FAMILIES FIRST CORONAVIRUS RESPONSE ACT LEAVE REQUEST FORM

An employee requesting leave under the Families First Coronavirus Response Act ("FFCRA") may only take leave for a qualifying reason, all of which are listed below. To approve your leave request, you must provide us with information about the reason(s) for which you seek leave, and, where applicable, how you wish to be compensated.

Please note that leave under the FFCRA will not be approved until this form and any additional information needed has been provided.

GENERAL INFORMATION

1. **Name:** _____

2. **Job Title:** _____

3. **Date or Date(s) for which Leave is Requested:** _____ - _____

4. **Are you requesting to take leave intermittently?*** Yes_____ No_____

   If yes, please specify your proposed intermittent schedule:_____
   _____.

   *Please note that intermittent leave is only available for certain types of leave, at our discretion. Requests for intermittent leave will be considered on a case-by-case basis, depending on the type of leave requested, position and business needs.

5. **Have you taken FFCRA leave before with another employer**? Yes_____ No_____
   If so, please state how much leave you took and identify the qualifying reason for which it took it:_____
   _____.

II. FFCRA QUALIFYING REASON FOR LEAVE

I certify that I am unable to work or telework for the following reason:

☐ 1. **I am subject to a Federal, State or local quarantine or isolation order related to COVID-19.**
- Name of governmental entity that issued the quarantine or isolation order: _____

☐ 2. **I have been advised by health care provider to self-quarantine due to concerns related to COVID-19.**
- Name and title of health care provider: _____

☐ 3. **I am experiencing COVID-19 symptoms and I am seeking a medical diagnosis.**

☐ 4. **I am/will be taking care of someone who (a) is subject to a Federal, State, or local quarantine or isolation order; or (b) has been advised by a health care provider to self-quarantine due to concerns related to COVID-19.**

- Name of individual for whom I am providing care:_____
- Relationship of individual to me:_____
- If applicable, name of governmental entity that issued the quarantine or isolation order:_____
- If applicable, name of health care provider who recommended that the individual to whom I am/will be providing care self-quarantine due to concerns related to COVID-19:_____

☐ 5. **I am/will be caring for my child/children whose school or place of care is closed, or whose child care provider is unavailable, due to COVID-19 precautions.** ***Employees who need leave for this reason must complete Attachment A.***

☐ 6. **I am experiencing a 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.**

- Describe applicable condition: _____

III. COMPENSATION

The FFCRA contains two paid leave provisions, the Emergency Paid Sick Leave Act ("EPSLA"), which provides for up to 80 hours of paid leave, and, the Emergency Family and Medical Leave Expansion (EFMLEA), which provides for up to 12 weeks of leave, the first 2 weeks of which are unpaid and the remaining 10 weeks are paid.

The EPSLA allows leave for qualifying reasons 1-3, which is paid at the greater of (1) your regular rate or (2) the applicable minimum wage, up to a maximum of $511 per day or $5,110 in the aggregate per employee.

The EPSLA permits leave for qualifying reasons 4-6, which is paid at 2/3 the greater of (1) your regular rate or (2) the applicable minimum wage, up to a maximum of $200 per day or $2,000 in the aggregate per employee.

In addition, the EFMLEA provides for leave for qualifying reason 5, which is unpaid for the first 2 weeks, but paid at 2/3 the greater of (1) your regular rate or (2) the applicable minimum wage, up to a maximum of $200 per day or $10,000 in the aggregate per employee.

For employees taking EFMLEA leave:

If you would like, you may but are not required to use EPSLA leave in order to receive payment during the first two weeks of EFMLEA leave. Please indicate your preference by checking the appropriate box:

☐ I want to use any EPSLA and EFMLEA time concurrently so that any EPSLA payments for which I may be eligible will be used during the first 10 days of my leave.

☐ I wish to take EFMLEA leave only and understand that the first 2 weeks of my leave will be unpaid unless I elect to or am required to substitute any accrued, unused time off I have available.*

** Employees who are taking EFMLEA leave, but who choose not to use EPSLA leave during the first two weeks, may be required, at our discretion, to use any other accrued paid time off they have available under our existing polices, if the policies would allow use of such accrued paid time for reason 5.*

Supplementation of FFCRA benefits:

In some instances, employees may be permitted, at our discretion, to use any unused, accrued paid time off that they have available under our existing policies to supplement the pay available for leave taken under the FFCRA such that the employee receives their full normal pay during the periods of leave. If you are requesting such supplementation, please check here:

☐ I request that I be permitted to use my accrued, unused paid time off to supplement my EFMLEA and/or EPSLA benefits so that I can receive 100% of my regular pay.

I certify that all information in this request for FFCRA leave, including any information in Attachment A, is true and complete. I agree and acknowledge that falsified information, misrepresentations or omissions in this request or any other related materials may result in disciplinary action, up to and including termination of employment. I further acknowledge and understand that, to the extent permitted by applicable law, any child care related leave will be counted as FMLA leave towards the FMLA's 12 week leave limit (or 26 week limit for leave to care for certain servicemember family members with a serious injury or illness) in a 12-month period.

_____ _____

Employee Signature Date

ATTACHMENT A

ADDITIONAL REQUIREMENTS FOR EMPLOYEES WHO NEED LEAVE TO CARE FOR THEIR CHILD/CHILDREN

A. Names/Ages of Your Child/Children for whom You Will Be Caring

	Name of Child	Age	Names of School, Place of Care, or Child Care Provider
1.			
2.			
3.			
4.			

(Please attach an additional sheet of paper with names/age of your children if necessary)

B. Certifications

1. Sole Provider Certification

I certify and represent that no other suitable person will be providing care for the child/children described in Part A above during the period for which I am requesting child care related leave.

_____
Employee's Signature

2. Special Circumstances Requiring Leave to Care for a Child Older than Fourteen

With respect to any child over 14 years old listed in Part A above, special circumstances exist requiring me to provide care to such child/children. Specifically,_____
_____.
(Please attach an additional sheet if necessary)

_____
Employee's Signature

_____
Date