



GRAHAM INDEPENDENT SCHOOL DISTRICT

LEAVE REQUEST FORM—EMERGENCY PAID SICK LEAVE AND EXPANDED FAMILY AND MEDICAL LEAVE

Table with 2 columns and 4 rows: Name, Department/campus, Email, Date; Phone number, Position, Duration of leave, Return to work on.

Leave benefits under the Families First Coronavirus Response Act (FFCRA) apply for the limited time period of April 1, 2020, to December 31, 2020. The amount of paid leave an employee may receive will vary depending on the reason leave is taken. Detailed information is available in the Employee Rights notice that can be found Grahamisd.com.

An employee requesting emergency paid sick leave and expanded family and medical leave must complete this form and return it to _____ as soon as the need for leave is identified. Documentation supporting the need for leave should be included when the request is submitted.

Emergency Paid Sick Leave (EPSL) is limited to 80 hours of paid leave at the following rates:

- Self: regular rate of pay up to \$511 per day
• For care of an individual or a son or daughter: two-thirds the regular rate of pay up to \$200 per day

Expanded Family and Medical Leave (EFML) provides up to 12 weeks of leave to care for a son or daughter when school is closed or child care is unavailable due to COVID-19. The first two weeks are unpaid, although the employee may access EPSL or other paid leave during this time. The remaining 10 weeks are two-thirds the regular rate of pay up to \$200 per day.

I request leave for the following reason(s):

Self

___ I'm subject to a federal, state, or local quarantine or isolation order related to COVID-19.

Name of entity requiring quarantine or isolation: _____

___ I've been advised to self-quarantine by a health care provider.

Name of health care provider requiring self-quarantine: _____

___ I'm experiencing symptoms of COVID-19 and am seeking a medical diagnosis.

Name of health care provider: _____



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Care for other individual or child

I'm unable to work in order to care for a minor son or daughter because their school is closed or child care is not available due to COVID-19.

Name of school or child care facility: _____

Are you the only adult caring for the child(ren): ____yes ____no

Name and age of child(ren): _____

If the son or daughter is over the age of 14 describe special circumstance requiring the care:

I'm unable to work in order to care for an individual subject or advised to quarantine or isolate.

Name of individual: _____ Relationship: _____

Name of health care provider: _____

Accrued leave use

EPSL:

(Include if allowed by the employer)

I choose to use accrued paid leave to supplement the 2/3 pay covered by EPSL so I receive 100 percent of my regular rate of pay.

EFML:

(Include if the employer requires concurrent use of leave with EFML)

I understand I'm required to use my accrued state and local leave concurrently with EFML. When accrued leave is exhausted, I will receive 2/3 pay for any remaining EFML.

Designation (completed by HR Department and a copy provided to the employee):

The employee qualifies for EPSL.

The employee does not qualify for EPSL.

The employee qualifies for ____ weeks of EFML.

The employee does not qualify for EFML.

For office use only: Date of Employment _____ Medical certification provided ____Yes ____ No Approved by: _____ Name and title Date: _____

