State of Connecticut Human Resources
Employee Request
Families First Coronavirus Response Act (FFCRA or Act)
Emergency Paid Sick Leave and/or Emergency Family and Medical Leave
Effective April 1, 2020 through December 31, 2020

For information about specific leave entitlements, contact your Human Resources Office

(To be completed by Employee)

Form **#: FFCRA - HR1**
Revision Date: **4/7/2020**

Employee Name _____ **Employee No.** _____
Official Job Title _____ **Agency** _____
Supervisor _____ **Supervisor Phone No.** _____
Work Location _____ **Shift** _____**Hours** _____
Home Address _____
City_____ **State** _____ **Zip Code** _____
Employee's Personal Phone No. _____
Employee's Personal Email _____

LEAVE ENTITLEMENT REQUESTED:

____ **Emergency Paid Sick Leave Act (EPSLA)** - Up to two weeks (80 hours, or a part-time employee's two-week equivalent) of paid sick leave paid at:
• 100% for qualifying reasons #1-3 below, up to $511 daily and $5,110 total; or
• 2/3 pay for qualifying reasons #4, 5 and 6 below, up to $200 daily and $2,000 total.
NOTE: EPSLA may be taken in addition to EMFLEA or concurrently with EFMLEA during the first two weeks of unpaid EFMLEA.

____ **Emergency Family and Medical Leave Expansion Act (EFMLEA) (Applicable to Reason 5 below only)** - Up to 12 weeks of expanded family and medical leave of which the first 2 weeks are unpaid and the remaining 10 weeks are paid at 2/3 for qualifying reason #5 below for up to $200 daily and $12,000 total).

_____ **Check here if you are requesting to utilize EPSLA leave during the first two weeks of EFMLEA leave.**

REASON FOR LEAVE: (*Check reason)*

1. _____ You are under a Federal, State, or local quarantine or isolation order related to COVID-19
2. _____ You have been advised by a health care provider to self-quarantine related to COVID-19
3. _____ You are experiencing COVID-19 symptoms and are seeking a medical diagnosis;
4. _____ You are caring for an individual subject to a Federal, State, or local quarantine or isolation order related to COVID-19 or the individual has been advised by a health care provider to self-quarantine related to COVID-19;
5. _____ You are caring for a child whose school or place of care is closed (or childcare provider is unavailable) for reasons related to COVID-19; or
6. _____ You are experiencing any other substantially similar condition specified by the Secretary of Health and Human Services, in consultation with the Secretaries of Labor and Treasury.

INFORMATION AND DOCUMENTATION REQUIRED:

Are you currently teleworking? _____ Yes _____No
If yes, explain why you are unable to continue teleworking

_____
_____
_____
_____

CAREGIVER LEAVE: For reason 4 or 5 above, indicate the following for the individual you are caring for:
Name: _____ Relationship: _____

For reasons 1, 2 and 4 above: Provide a copy of the quarantine/isolation order and/or medical opinion to self-quarantine and provide the medical provider's information below:
Name: _____ Telephone Number: _____
Address:_____

For reason 3 above: Provide the medical provider's information below:
Name: _____ Telephone Number: _____
Address:_____

For reason 5 above: Provide a copy of the notice of closure or notice of unavailability communication received and the information requested below:
Name of Child: _____ Age of Child:_____
Name of School/Childcare Provider: _____
Address:_____
Telephone Number: _____ Relationship_____
NOTE: The child must be under the age 18 (or age 18+ and incapable of self-care due to a disability), and there must be no other suitable person to care for the child during the period requested for leave.
_____ I confirm the above statement to be true.

For reason 6 above: Provide a description of any other substantially similar condition you are experiencing:

_____
_____

TYPE OF LEAVE REQUESTED: (Check all that apply)

☐ **Block Leave**: A continuous absence for a single qualifying reason (e.g., one month).
☐ **Reduced Schedule Leave**: A leave schedule that changes the employee's normal work schedule for a period of time by reducing the employee's usual number of working hours per workweek or hours per day.
☐ **Intermittent Leave**: Leave taken in separate blocks of time due to a single qualifying reason.

NOTE: Intermittent leave and reduced schedule leave are not available in all situations. Availability of these types of leave depends upon the reason for leave and your eligibility for specific leave entitlements. Contact your HR Department for more information.

Duration of Leave: *(from)* _____ *(to)* _____
(month/day/year) (month/day/year)

Please describe your leave request:

_____

_____

_____

REQUESTED USE OF ACCRUALS (If <u>not</u> utilizing EPSLA during first two weeks of EFMLEA leave:

- The choice to use your accruals during the first two weeks of the unpaid EFMLEA leave during your absence must be made before you begin your leave.
- If you do not elect to use your accruals, the first two weeks of EFMLEA leave will be unpaid
- If you choose not to use all your accruals or if your accruals are exhausted before the first two weeks of EFMLEA leave ends, the remainder will be unpaid.
- You cannot intermingle unpaid time with paid time.

Fill In Chart: You must designate the number of days, or hours, or you may indicate "ALL available" and indicate the order of priority in which you would like the accruals used:

USE OF ACCRUALS	**Sick Leave Accruals**	**Vacation Accruals**	**Personal Leave**	**Comp Time**	**Holiday Comp Time**	**Rowland SEBAC VAC**	**Rowland SEBAC PL**
REASON 5: You are caring for a child whose school or place of care is closed (or childcare provider is unavailable) for reasons related to COVID-19	**Days/ Hours**	**Days/ Hours**	**Days/ Hours**	**Days/ Hours**	**Days/ Hours**	**Days/ Hours**	**Days/ Hours**
Indicate Number of Hours to Use							
Indicate Priority Order to Use for Above Hours							

_____ _____

(Employee Signature) **(Date)**

Return the completed form(s) to your agency Human Resources Office.