To request Emergency Paid Sick Leave as provided under the Families First Coronavirus Response Act (FFCRA), please complete and submit the following request form to your Supervisor and/or Human Resources as soon as possible before leave commences. Verbal notice will be accepted until a form can be provided.

Employee Name (print clearly): __________________________________________

Department: ___________________________ Supervisor: ______________________

Requested Leave Start Date: _______________ Estimated End Date: _______________

The amount of Emergency Paid Sick Leave being requested is _________ hours. The reason for this Emergency Paid Sick Leave request is (check the appropriate reason below and provide the required information):

I am unable to work, including unable to telework, because...

SELECT ONE

☐ 1) I am subject to a federal, state, or local quarantine or isolation order related to COVID-19.

   Name of government entity that issued the order: _____________________________

☐ 2) I have been advised by a health care provider to self-quarantine due to concerns related to COVID-19.

   Name of the health care provider making the recommendation: __________________

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

☐ 4) I am caring for an individual who is subject to either number 1 or 2 above.

   Name of government entity that issued the order: _____________________________

   OR

   Name of the health care provider making the recommendation: __________________
5) I am caring for my child whose primary or secondary school or place of care has been closed, or my childcare provider is unavailable due to COVID-19 precautions.

Name and age* of the child being cared for: ________________________________

Name of school, place of care, or child care provider: ________________________________

(By signing this form, you are affirming that no other suitable person is available to care for the child during the period of requested leave)

6) I am experiencing another substantially similar condition specified by the Secretary of Health and Human Services.

I certify that the above information is accurate and complete.

Employee Signature: ________________________________ Date: __________________

* With the care of a child older than 14 during daylight hours, you must submit a statement that special circumstances exist requiring the employee to provide care.

Questions? Call or email Human Resources:
Phone: 815-547-4770
Fax: 815-547-3579
Email: dstreed@boonecountyil.org
https://www.boonecountyil.org/HR

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