2021
REQUEST FORM FOR LEAVE OF ABSENCE
Related to COVID-19

In order to be eligible for this leave, you must meet the requirements in the Families First Coronavirus Response Act (FFCRA).

Employee Name (Last, First):	Employee Number:
Department:	
Employee Information	
Payroll Title:	
Personal E-mail Address	Work E-mail Address
Home Telephone	Cell Telephone
Supervisor Information	
Name	Title
E-mail Address	Work Telephone

Section 1: Employee Leave Request

1. I am requesting the following leave (check all that apply):

☐ **Emergency Paid Sick Leave.** *If requesting this leave, complete Section 2.*

Requested Start Date:	Requested End Date:

Type of Leave Requested (check one):

☐ Continuous
☐ Intermittent. Please provide details of requested leave schedule:

_____

☐ **Expanded Family & Medical Leave.** *If requesting this leave, complete Section 3.*

Requested Start Date:	Requested End Date:

Type of Leave Requested (check one):

☐ Continuous
☐ Intermittent. Please provide details of requested leave schedule:

_____

Section 1 (continued)

2. I currently have, or have had within the last twelve months, approval for FMLA leave time? (Yes/No): _____

3. Check one of the following

☐ This is my initial leave request.

☐ This is a supplemental request to extend previously requested and approved leave.

SECTION 2 – EMERGENCY PAID SICK LEAVE (EPSL)

Check in left column all qualifying reasons for leave request.

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

A. Provide Government Agency that issued the order:

☐ Federal Centers for Disease Control and Prevention (CDC)
☐ State of California, Governor's Office
☐ Other: _____

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

A. Provide name of health care provider that advised self-quarantine:

_____

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

A. Provide name of health care provider that will be providing medical diagnosis:

_____

☐ 4. I am caring for an individual who is subject to a federal, state, or local quarantine or isolation order related to COVID-19, or who has been advised by a health care provider to self-quarantine due to concerns related to COVID-19.

A. Provide Name of Individual Being Cared For and their relationship to you:

_____

B. Provide Government Agency that issued the order:

☐ Federal Centers for Disease Control and Prevention (CDC)
☐ State of California, Governor's Office
☐ Other: _____

C. Provide name of health care provider that advised self-quarantine:

_____

Section 2 (continued)

☐ 5. I am caring for my son/daughter* whose school or place of care has been closed, or whose child care provider is unavailable, due to COVID-19 precautions; and there is no other suitable person to care for my son/daughter.

A.1 Provide Name of Child(ren) Being Cared For:_____

Provide Name of School/Care Center/Care Provider that is closed or unavailable due to COVID-19:_____

A.2 Provide Name of Child(ren) Being Cared For:_____

Provide Name of School/Care Center/Care Provider that is closed or unavailable due to COVID-19:_____

A.3 Provide Name of Child(ren) Being Cared For:_____

Provide Name of School/Care Center/Care Provider that is closed or unavailable due to COVID-19:_____

☐ 6. I am experiencing a substantially similar condition specified by the Secretary of Health and Human Services, in consultation with the Treasury and Labor Departments.

Provide specified substantially similar condition: _____

_____

SECTION 3 – EXPANDED FAMILY & MEDICAL LEAVE

Check in left column all qualifying reasons for leave request.

☐ 7. My son or daughter's school or place of care has been closed due to COVID-19; and there is no other suitable person to care for my son/daughter.

A.1 Provide Name of Child(ren) Being Cared For:_____

Provide Name of School/Care Center/Care Provider that is closed or unavailable due to COVID-19:_____

A.2 Provide Name of Child(ren) Being Cared For:_____

Provide Name of School/Care Center/Care Provider that is closed or unavailable due to COVID-19:_____

A.3 Provide Name of Child(ren) Being Cared For:_____

Provide Name of School/Care Center/Care Provider that is closed or unavailable due to COVID-19:_____

Section 3 (continued)

☐ 8. My son or daughter's care provider is unavailable due to COVID-19; and there is no other suitable person to care for my son/daughter.

A.1 Provide Name of Child(ren) Being Cared For:_____

Provide Name of School/Care Center/Care Provider that is closed or unavailable due to COVID-19:_____

A.2 Provide Name of Child(ren) Being Cared For:_____

Provide Name of School/Care Center/Care Provider that is closed or unavailable due to COVID-19:_____

A.3 Provide Name of Child(ren) Being Cared For:_____

Provide Name of School/Care Center/Care Provider that is closed or unavailable due to COVID-19:_____

*"son or daughter" includes someone:

A) under 18 years of age, or
B) 18 years of age or older who (1) has a mental or physical disability, and (2) is incapable of self-care because of that disability

Certification: I am unable to work or telework and hereby request leave/approved absence from duty as indicated above and certify that such leave/absence is requested for the purpose(s) indicated. I understand that I must comply with my employing department's procedures for requesting leave/ approved absence (and provide additional documentation, including medical certification, if required) and that falsification of this form may be grounds for disciplinary action, including discharge. I understand and fully acknowledge that, should an overpayment occur, I am required to repay the number of hours of paid leave I was not entitled to.

_____ _____

Employee Signature Date

Privacy Act

Section 6311 of Title 5, United States Code, authorizes collection of this information. The primary use of this information is by management and your payroll office to approve and record your use of leave. Additional disclosures of the information may be: to the Department of Labor when processing a claim for compensation regarding a job connected injury or illness; to a State unemployment compensation office regarding a claim; to Federal Life Insurance or Health Benefits carriers regarding a claim; to a Federal, State, or local law enforcement agency when your agency becomes aware of a violation or possible violation of civil or criminal law; to a Federal agency when conducting an investigation for employment or security reasons; to the County of Los Angeles Department of Human Resources or the Chief Executive Office when the information is required for evaluation of leave administration; or the Internal Services Department in connection with its responsibilities for records management.

FOR DEPARTMENTAL USE ONLY

☐ Approved as requested by employee.

☐ Request is approved with the following modification:

_____

_____

_____

_____

_____

_____

☐ Request is NOT approved.

_____ _____

DEPARTMENT HEAD/DESIGNEE SIGNATURE DATE

_____

DEPARTMENT HEAD/DESIGNEE NAME