Families First Coronavirus Response Act (FFCRA) Emergency Paid Leave Request Form

Employee Name: _____ **Employee ID**: _____ **Dates for which leave is being requested**: _____

Phone #: _____ **Email:**_____ **Supervisor Name:**_____

Check the box for the leave request reason and answer the questions located to the right of the reason. Submit this signed form to your supervisor and hr@jjkllc.com. Approved leave commences on the day the request form was received.

Select the appropriate qualifying reason:	**Document answers to the following:**
☐ Local, State, Federal quarantine order Full regular pay, up to $511/day (80-hour cap)	Issuing Authority: Effective Dates:
☐ Healthcare Provider directed quarantine Full regular pay, up to $511/day (80-hour cap)	Healthcare Provider Name: Quarantine Dates:
☐ Seeking medical diagnosis for COVID-19 symptoms Full regular pay, up to $511/day (80-hour cap)	Healthcare Provider Name: Appointment Date:
☐ Caring for a person under local, State, Federal or Healthcare Provider directed quarantine 2/3 regular pay, up to $200/day (80-hour cap)	Name and relation of person you're caring for: Quarantine Dates:
☐ Providing childcare due to school or provider being closed due to COVID-19 and no other suitable option 2/3 regular pay, up to $200/day (80-hour cap for employees with < 30 days of service; up to 12-weeks for employees with > 30 days service)	Name of School/Childcare Provider: Closure Dates (Start – Anticipated End): Name and Age of Child(ren) being cared for: If older than 14, provide reason for childcare need: Reason there is no other suitable childcare option:

I attest the information provided on this form is accurate and complete. I understand falsification of information may lead to disciplinary action, up to and including termination.

X _____

Employee Signature and Date

HR USE ONLY:

Date Received:	Hdct on Date Received:
Hrly Rate:	Regular Workday Hrs:
Reg Daily Rate:	FFCRA Daily Rate Cap:
Mthly Health Premium:	Daily Health Pro-Rata:
Daily 1.45% Medicare:	Total FFCRA Tax Credit:
Company Paid Leave Supplement Daily $:	Hrs Equiv:
Approved or Denied:	