FFCRA LEAVE REQUEST FORM

(for use only from April 1 through December 31, 2020)

To request leave under the Families First Coronavirus Relief Act (FFCRA), you or your representative should complete this form and submit it to Maria Rellinger, Apollo Treasurer/CFO, by email (maria.rellinger@apollocc.org) or orally request leave by calling (419) 998-2912 to provide the required information.

Employee Name (print clearly): ____

Today's Date: ____________ Requested Leave Start Date: _____________ Estimated End Date: ____________

A. On what basis are you requesting leave (choose one)?

continuous intermittent reduced-schedule

B. Enter the number corresponding with the reason you are requesting leave: #_________

1. I am subject to a federal, state or local quarantine or isolation order related to COVID-19 and as a result I am unable to work or telework.
2. I have been advised by a healthcare provider to self-quarantine due to concerns related to COVID-19 and as a result I am unable to work or telework.
3. I am experiencing symptoms of COVID-19 and am seeking medical diagnosis from a health care provider and as a result I am unable to work or telework.
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 an individual who has been advised by a health care provider to self-quarantine due to concerns related to COVID-19 and as a result I am unable to work or telework.
5. I am caring for my child whose school or place of care has been closed or whose childcare provider is unavailable because of COVID-19 and no other suitable person is available to care for my child and as a result I am unable to work or telework.
6. I am experiencing a substantially similar condition specified by the U.S. Department of Health and Human Services and as a result I am unable to work or telework.

C. Answer the corresponding number below that matches your answer to item B above. *(e.g., if you entered "1" above then complete only "1" below)*. ***Please provide documentation from the entity/provider.***

1. State the name of the government entity that issued you a quarantine or isolation order related to COVID-19: ____
2. State the name of the healthcare provider who advised you to self-quarantine due to concerns related to COVID-19: ____
3. State the name of the healthcare provider from whom you are seeking a medical diagnosis related to symptoms of COVID-19: ____
4. As applicable, state either (a) the name of the government entity that issued the quarantine or isolation order related to COVID-19 to the individual being cared for; or (b) the name of the healthcare provider that advised the individual being cared for to self-quarantine due to concerns related to COVID-19:

   ____
5. State: (a) name of child being cared for; (b) name of the school, place of care, or childcare provider that has closed or is now unavailable; and (c) that no other suitable person is available to care for the child (explain).

   a) ____

   b) ____

   c) ____
6. Describe the condition that makes you unable to work or telework:

____ __________________

Signature Date