University of Wisconsin–System

Request for Leave under Federal Emergency COVID-19 Leave Programs

(Use this form to request leave taken from August 1, 2020 through December 31, 2020)

Please print out and complete this form or complete it electronically.
Please email the completed form to the Office of Human Resources at hr@uwgb.edu. They are responsible for handling confidential medical information.

➡ Please complete sections 1 through 5. If you need assistance with this form**,** contact your HR Dept.**.**

Section 1: Personal and Contact Information

Name:		Employee ID:	For office use only
Job Title:		Supervisor:	
Department:		Preferred phone number:	
Preferred email address while on leave:		What is the best way to reach you?	Preferred email Preferred phone number

Additional Information

▭ I've been employed for at least 30 days prior to the first day of my leave. (EFMLA requirement only)
▭ I have had an approved FMLA leave in the previous 12 months. (EFMLA only)

Section 2: Reason(s) for Leave Request

- You may qualify for paid leave under the federal program called the Families First Coronavirus Response Act
- Your HR Dept. will use the information below to determine which paid leave program(s) you may qualify for. If you qualify for more than one federal leave program, your HR Dept. will choose the leave program that gives you the greatest benefit. When eligible, leave programs may run concurrently.

	Indicate the reason(s) you are requesting leave below. **Check all that apply.**	For office use only		
		EPSL	EPSL or EFMLA	EFMLA
	I am unable to work my full shift, including telework, because:			
2.1	I am subject to a federal, state, or local quarantine or isolation order related to COVID-19, or I am unable to work a scheduled shift due to my employer closing my workplace. *(Please complete Section 4, question A.)*		░	░
2.2	▭ I have been advised by a health care provider to self-quarantine because of COVID-19. *(Please complete Section 4, question B.)*		░	░
2.3	▭ I am experiencing symptoms of COVID-19 and am seeking a medical diagnosis. (*Please complete Section 4, question B.*)		░	░
2.4	▭ I am caring for an individual who is subject to a quarantine or isolation order or has been advised to self-quarantine. *(Please complete Section 4, question C.)*		░	░
2.5	▭ I am caring for my minor child whose school or place of care is closed, or childcare provider is unavailable due to COVID-19 precautions. For minor children over the age of 14, I have described the special circumstances requiring I provide care to my child(ren). *(Please complete Section 4, question D.)*	░		
2.6	▭ I am experiencing substantially similar conditions as specified by the Secretary of Health and Human Services, in consultation with the Secretaries of Labor and Treasury. *(Please complete Section 4, question B.)*	░		░

Section 3: Anticipated Dates Requesting Leave

Date of Leave	Start time	End time	Hours		Date of Leave	Start time	End time	Hours

Describe any leave request not reflected in the boxes above *(note that these require supervisor approval)*:

_____

Section 4: Information and/or Documentation Required

If directed by your supervisor provide the requested information based on reason(s) you provided in Section 2.

➡ Questions B, C and D below require written documentation that you must provide to your Human Resources Dept. no more than 15 calendar days after the first day of your leave request, if required by supervisor.

A. *Section 2.1, page 1:* If you are unable to work or telework because you are subject to a federal, state, or local quarantine or isolation order related to COVID-19, other than a state or local order substantially similar to the Wisconsin "Safer at Home" order, please indicate the name of the government entity that issued the quarantine or isolation order, or issued the decision to close your workplace.

_____

B. *Section 2.2, 2.3 or 2.6, page 1:* If you have been advised by a health care provider to self-quarantine because of COVID-19, or if you are experiencing symptoms of COVID-19 and are seeking a medical diagnosis, or if you are experiencing substantially similar conditions as specified by the Secretary of Health and Human Services, in consultation with the Secretaries of Labor and Treasury — you must provide written documentation from your health care provider advising you to self-quarantine, or documentation from your health care provider who was consulted regarding your COVID-19 symptoms or diagnosis.

☐ Documentation attached or will be provided separately

C. *Section 2.4 on page 1:* If you are caring for an individual who is subject to a quarantine or isolation order or has been advised to self-quarantine, you must provide written documentation from the individual's health care provider advising quarantine, or advising on care related to the individual's COVID-19 symptoms or COVID-19 diagnosis.

☐ Documentation attached or will be provided separately

D. *Section 2.5 on page 1:* **Respond to these questions** if you are caring for a minor child whose school or place of care is closed, or childcare provider is unavailable, due to COVID-19 precautions.

1. Name(s) and age(s) of child(ren) to be cared for: _____
   _____

2. For child(ren) over the age of 14, please provide a statement that explains the special circumstances requiring you to provide care to your child(ren) during daylight hours: _____
   _____

3. Name of the school(s) or place of care that is closed and/or childcare provider that is unavailable during the period for which you are requesting leave: _____

☐ My signature on page 3 certifies that no other suitable person will be caring for my child(ren) during the period of time that I am taking leave under the Families First Coronavirus Response Act (FFCRA).

Section 5: Signatures

I am requesting leave under the Families First Coronavirus Response Act because **I am unable to work my full shift, including telework**, for the reason(s) and during the time period I have indicated on this form.

- 3 -

_____   _____
Employee Signed or Typed Signature *(Required)*   Date

_____   _____
HR Approval Signature   Date

_____   _____
Supervisor Signature   Date
  (Required for intermittent and/or reduced leave schedule)