

**Request for Emergency Leave under the Families First Coronavirus Response Act (FFCRA)
Emergency Paid Sick Leave Act and Emergency Family and Medical Leave Expansion Act**

Qualifying employees may take a total of 12 workweeks of leave during a 12-month period under the FMLA, including the Emergency Paid Sick Leave Act and Emergency Family and Medical Leave Expansion Act. To request leave under the FFCRA, provide all of the required information and submit to <email address> <Employer name and address>, along with all required supporting documentation. **If Emergency leave is granted, the Fund Office will be notified and your health care coverage will be continued in accordance with the provisions related to FMLA leave as described in the Summary Plan Description (SPD).**

Employee Name: _____ Date: _____

This is a (choose one): New request for leave Request for an extension of leave

Requested leave start date: _____ Expected return to work date: _____

I am requesting emergency paid sick leave for the following reason:

<input type="checkbox"/>	I am subject to a federal, state, or local quarantine or isolation order related to COVID-19. Name of governmental entity issuing order: _____
<input type="checkbox"/>	I have been advised by a health care provider to self-quarantine related to COVID-19. (<i>Attach documentation from provider advising self-quarantine.</i>) Name and phone number of provider: _____
<input type="checkbox"/>	I am experiencing COVID-19 symptoms and seeking a medical diagnosis. Name and phone number of provider: _____ Date of medical visit: _____ Date results expected: _____
<input type="checkbox"/>	I am caring for an individual who is subject to a federal, state, or local quarantine / isolation order. Name of governmental entity issuing order: _____ Name of the individual for whom you are caring: _____ Relationship to you of the individual for whom you are caring: _____
<input type="checkbox"/>	I am caring for an individual who has been advised by a health care provider to self-quarantine related to COVID-19. (<i>Attach documentation from provider advising self-quarantine.</i>) Name and phone number of provider: _____ Name of the individual for whom you are caring: _____ Relationship to you of the individual for whom you are caring: _____
<input type="checkbox"/>	I am caring for a child under age 18 whose school or place of care is closed, or childcare provider is unavailable due to COVID-19 reasons, and no other person will be providing care for the child(ren) during my normal work time. (<i>Attach announcement or other documentation of closure or provider unavailability.</i>) Age of the individual for whom you are caring: _____ Relationship to you of the individual for whom you are caring: _____

Pursuant to the FFCRA, the first 10 days of your FMLA leave is unpaid, however you may be eligible for emergency paid sick leave provided through the FFCRA, in which case this sick leave will be paid.

I certify that the above information is accurate and complete, and I have attached or included the required documentation. I attest and agree that I am unable to work including telework and will not work for another Contributing Employer during the time I am on emergency leave.

Employee Signature: _____

Employer Signature: _____ Leave granted Leave denied